PASTORS ON PENDULUMS:

AN ANTI-SANIST AND DIALECTICAL PASTORAL THEOLOGICAL REFLECTION ON CARING FOR INDIVIDUALS WITH SCHIZOPHRENIA IN THE KOREAN CHURCH

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by

Minhwan Song

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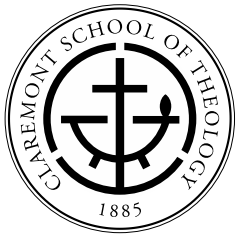

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Abstract

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Schizophrenia is considered one of the most challenging and stigmatized experiences of mental distress. Persons with schizophrenia are often excluded from the scope of pastoral care and are marginalized in the Korean church. The exclusion of schizophrenia from pastoral care can be attributed to sanist cultural and theological understandings of these individuals and their lived experiences. The sanist, life-limiting embedded theology of pastoral care often leaves pastoral caregivers and the church feeling constrained, confused, and inadequate in their pastoral care provision.

This dissertation examines the caregiving narratives of seven Korean Protestant pastors, utilizing critical narrative analysis integrated with the "thinking with theory" approach (Jackson and Mazzei 2012) to analyze their understanding of living with schizophrenia within Korean society and the church, as well as their reflections on their pastoral care interactions with individuals with schizophrenia. This critical narrative analysis specifically focuses on the various dilemmas these pastoral caregivers confront and the issues of injustice and sanist sociocultural norms that underlie these dilemmas. Using dialectical thinking, the analysis further explores untapped and unfulfilled possibilities of spiritual care and their values.

The dissertation concludes by proposing a critical spiritual care approach for people living with schizophrenia. This approach aims to be anti-sanist and Mad-inclusive while also adopting a dialectical and practical stance, taking into consideration the lived realities of

schizophrenia within both society and the church. This new approach seeks to empower and sustain spiritual caregivers, individuals and groups living with schizophrenia, mental health experts, and the faith community as they work together to build an environment that enables individuals with schizophrenia to live and thrive fully within Korean and global society.

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Yeeun and Sia, you are the loves of my life, who continuously give me the energy to live and motivate me to become a better person every day.

I am deeply indebted to my parents and sister, whose countless prayers, love, and care have shaped me into who I am. To my family, relatives, friends, colleagues, and academic and spiritual mentors: without your support, love, advice, encouragement, inspiration, and friendship, I could not have completed this long, lonely, and exhausting journey.

I would like to express my sincere gratitude to my committee members, Drs. K. Samuel Lee, Duane R. Bidwell, and Sheryl A. Kujawa-Holbrook, whose academic expertise and ministry experiences continuously inspired me to question, criticize, and refine my arguments to be not only theoretically valid and provocative but also pragmatic and relevant within the church context. Your passion for teaching and love for your students provide me with excellent role models that I will strive to emulate throughout my upcoming journey.

All of my research participants have been great teachers to me, with their sincere hearts for God, ministry, and people. They have helped me broaden my perspectives beyond theoretical knowledge and reaffirm the power of faith and pastoral care.

I dedicate this dissertation to my late grandparents, who gave me unconditional love, and to my uncle, whose so many untapped potentials I once mourned; now, I am grateful for his existence, which has significantly inspired this study.

I do not know where my path lies ahead, but as I look back on my traces, I truly believe and confess, “Surely goodness and mercy of my God shall follow me all the rest of my days” (Psalm 23:6a).

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Chapter 1

Introduction

Existing paradigms of mental illness in the spiritual care of people with schizophrenia have proven inadequate and ineffective.[1] These paradigms still hold a sanist perspective of individuals with schizophrenia, categorizing them as irrational, dangerous, abnormal, and inferior. Furthermore, in the Korean church context, being identified as having a severe mental illness, including schizophrenia, leads to cultural and religious stigmatization due to the sanist views embedded in cultural and theological beliefs associated with people having such a diagnosis or lived experiences of mental illness.

My dissertation argues for an alternative spiritual care paradigm for people living with schizophrenia that brings to light the wisdom, meaning, and value they bring to the world from their lived experiences and presents ways spiritual care can be more effectively and inclusively planned and provided. This paradigm takes an anti-sanist, mad-affirming, relationship-and-justice-centered approach, drawing on critical studies disciplines. The paradigm is built upon the reflection of alternative perspectives on the realities of people's lived experiences with schizophrenia and a critical reexamination of the various dilemmas that occur in caring relationships.

[1] See John Swinton, *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems* (Nashville: Abingdon Press, 2000); Elahe Hessamfar, *In the Fellowship of His Suffering: A Theological Interpretation of Mental Illness—a Focus on "Schizophrenia"* (Eugene, OR: Cascade Books, 2014); for a discussion on mental illness more broadly, see Anastasia Philippa Scrutton, "Is Depression a Sin or a Disease? A Critique of Moralizing and Medicalizing Models of Mental Illness," *Journal of Disability & Religion* 19, no. 4 (October 2, 2015): 285–311, https://doi.org/10.1080/23312521.2015.1087933.

The revised paradigm proposed is expected to dismantle "sanism"[2] within the Korean church and the provision of spiritual care and help guide caregivers in their critical theological deliberation. It uses a dialectical approach to analyze the challenges and dilemmas faced by pastoral caregivers. The model aims to assist spiritual caregivers in devising and implementing more just, equal, mutually beneficial, pragmatic, and sustainable spiritual care plans. The new paradigm argues that the church, as a community, has a vital role in embracing mental illness as a human difference and, therefore, the responsibility to support and advocate for caring relationships between people with lived experiences of mental illness and their caregivers.

Discussion of the Problem

Pastoral care for people with a psychiatric diagnosis of schizophrenia and their families, according to how it has been delivered in the North American Protestant Christian Church contexts, has been based on two theoretical understandings of mental illness. The premodern spiritual model primarily views mental illnesses as spiritually caused phenomena. The bio-psychiatric medical model frequently limits experiences of mental illness to psychopathological, medical phenomena.[3] Regardless of their different orientations to an understanding of schizophrenia and people who live with it, both of these paradigms are inadequate guides for providing effective, holistic care that empowers and sustains both those who provide pastoral care and those who receive care.

One of the reasons these two existing models do not work is their inability to address sanism effectively. Sanism is "a larger belief system" that consistently leads to "the systematic

[2] While the more detailed definition of sanism will be presented later in its discussion, it refers to the prejudicial and unjust perceptions and treatments of people living with psychiatric diagnoses or experiences identified by them on various levels, including the systemic level.

[3] See Anastasia Philippa Scrutton, "Is Depression a Sin or a Disease? A Critique of Moralizing and Medicalizing Models of Mental Illness"; Tasia Scrutton, *Christianity and Depression* (London: SCM Press, 2020); Marcia Webb, *Toward a Theology of Psychological Disorder* (Eugene, OR: Cascade Books, 2017).

subjugation of people who have received 'mental health' diagnoses or treatment."[4] Sanism has served to create and perpetuate "various forms of stigma, blatant discrimination, and a host of microaggressions" against people with mental illness.[5] On one hand, the spiritual model blatantly or surreptitiously blames the affected individuals or their parents and families for mental illness by equating one's adverse spiritual condition—either one's sinfulness or the influences of evil forces—with the causes of the mental illness.[6] On the other hand, the bio-psychiatric model, such as the brain disease model, highlights the neurological causes of schizophrenia, often disregarding or even refuting the patient's/family's responsibility for the onset and progression of the illness.[7] Neither the spiritual nor the bio-psychiatric models successfully resolve the issues of stigma and shame because both allow for assumptions about the nature and social implications of mental illness. These underlying assumptions suggest that individuals with mental illness are seen as less able, inferior, and burdensome, as a nuisance to others, and especially according to the medical model, as requiring forced medical and psychiatric control sanctioned by the state,[8] thus giving them the status of lesser human beings. Sanism degrades the existence of psychiatrized individuals in society, disqualifies their agency, and discredits their capacities by labeling them as irrational and dangerous. In doing so, it deprives them of their human rights.

As a universal phenomenon in every general context, but also specifically in the Korean context, sanism creates shame. Shame is experienced by people psychiatrically diagnosed with

[4] Jennifer M. Poole et al, "Sanism, 'Mental Health', and Social Work/Education: A Review and Call to Action," *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice* 1 (2012): 20.

[5] Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume, "Glossary of Terms," in *Mad Matters: A Critical Reader in Canadian Mad Studies*, ed. Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume (Toronto: Canadian Scholars' Press, 2013), 339.

[6] Scrutton, *Christianity and Depression*, 17-18; 30-31.

[7] Swinton, *Resurrecting the Person*, 77-81; E. Fuller Torrey, *Surviving Schizophrenia: A Family Manual*, 7th ed. (New York: Harper Perennial, 2019), 118-125.

[8] Tomi Gomory and Daniel J. Dunleavy, "Madness: A Critical History of 'Mental Health Care' in the United States," in *Routledge International Handbook of Critical Mental Health*, ed. Bruce M. Z. Cohen (London: Routledge, 2018), 117.

schizophrenia, their families, and even the health professionals who work with them. They are frequently identified as sharing or being affected by the traits socially assigned to individuals living with mental illness stigma, which label them as abnormal and insane and thus not to be included in the normal majority.[9] With a variety of connotations and implications, various mental illness stigmas in society and the church generate and intensify the shame experienced. In addition to the public and religious stigmas associated with schizophrenia, in the Korean Christian Church context, those who live with schizophrenia or have a family or in-group member living with schizophrenia feel shame because their experiences do not align with the traditional and/or contemporary Korean cultural and societal norms. A research project conducted by Sungeun Yang and Paul C. Rosenblatt highlights how the Korean neo-Confucian culture places community pressure on individuals and families to conform to those norms, emphasizing the need to look similar to others, based on the collective identity of "we."[10] Violating cultural norms by being identified as different or inferior due to their own or family's schizophrenia leads to their losing face, and this can generate and complicate their shame.

The sanist assumptions about schizophrenia deeply embedded in spiritual or the bio-psychiatric models, as well as the contexts of spiritual care, ultimately lead to essentializing people's psychiatric experiences and neglecting other areas of their lives. It is important not to limit the lives and identities of those with schizophrenia and their families to the experiences of psychiatric symptoms and consequential distress.[11] The exploration and reassessment of the

[9] Patrick W. Corrigan and Petra Kleinlein, "The Impact of Mental Illness Stigma," in *On the stigma of mental illness: practical strategies for research and social change,* ed. Patrick W. Corrigan (Washington, DC: American Psychological Association, 2005), 11-44.

[10] Sungeun Yang and Paul C. Rosenblatt, "Shame in Korean Families," *Journal of Comparative Family Studies* 32, no. 3 (Summer 2001): 361-375.

[11] Stephen Olson and Joretta L. Marshall, "Psychotic Disorders," in *Ministry with Persons with Mental Illness and Their Families,* ed. Robert H. Albers, William Meller, and Steven D. Thurber (Minneapolis: Fortress Press, 2019), 58.

often-overlooked and underestimated moments of living with schizophrenia, along with the significance of these moments beyond psychiatric discourse, can assist individuals with this lived experience, their families, spiritual caregivers, and society in reconsidering how to provide spiritual care as a form of affirmation and advocacy. This, in turn, can help them reclaim agency and capacity, enabling them to tap into their potential for achieving a full life.

This means the traditional understanding of what constitutes a caring relationship also needs to be reassessed and reconstructed. Traditionally, care provided to people with any dependent condition, whether by informal or formal caregivers, is deemed to be a one-sided, power-imbalanced relationship—one that requires sacrifice on the part of caregivers to be effective, safe, and long-lasting.[12] No matter how genuine and sincere caregivers' motives when caring for affected individuals, the asymmetric relationship between caregivers and the cared for diminishes care receivers' agency and capacities and neglects the diverse realities of care on the parts of caregivers and care seekers. Such an imbalance can also harm the well-being of care receivers. Therefore, the limited perspective on the nature and interplay among contextual factors of the care relationship in spiritual care for people with schizophrenia hinders the transformation of spiritual care into a more equal and mutually beneficial relationship.

Discussion of the Thesis

The thesis of my dissertation is that widely accepted understandings of mental illness, particularly schizophrenia, within the Korean Christian church context contain sanist views and attitudes. These attitudes lead to religious, social, and cultural prejudices, discrimination, injustices, and consequent negative emotional reactions among people who do not have lived experiences with mental illness. Therefore, it is essential to develop an alternative critical

[12] Eva Feder Kittay, *Learning from My Daughter: The Value and Care of Disabled Minds* (New York: Oxford University Press, 2019), 44; 181.

pastoral theological view on living with schizophrenia and a spiritual care model that employs an anti-sanist, dialectical approach.

To accomplish this, my dissertation maintains two research foci. First, it analyzes Korean pastors' and the Korean church's limited theological views of people with schizophrenia and their pastoral care, particularly pronounced through the dilemmatic moments they face during care. This analysis reveals underlying theological beliefs regarding mental illness, the challenges and dilemmas they pose in pastoral care, and how these beliefs interplay with the care decisions made by pastors. Upon the reexamination of pastoral care experiences with individuals with schizophrenia in the church, unattended dimensions of people's lived experiences are unearthed, values and virtues are highlighted, and alternatives for spiritual care intervention are envisioned. Viewing schizophrenia as diversity within the human experience acknowledges the agency of people with schizophrenia. It directly combats stigmas around people with schizophrenia that deem them inferior, non-credible, incapable of contributing meaningfully to others, and dangerous to be around. Instead, this new understanding calls us to know them as being unique and to welcome them as members of society and church—as those who are able to coexist, contribute, and reciprocate.

The second research focus is on the dialectical approach to understanding the insights gained from viewing schizophrenia as a unique human experience and acknowledging the validity of the care decisions made based on existing spiritual care paradigms and theological understandings of schizophrenia. It seeks to acknowledge both the experiential knowledge of the psychiatrized, and the distress, discomfort, risks, and disarray that accompany schizophrenia—both for the individuals themselves and the people around them, including pastoral caregivers.

This academic endeavor aims to transform the existing spiritual care model of people with lived experiences of schizophrenia and their spiritual caregivers into one that is more just, context-informed, practical, and empowering for everyone involved. The alternative critical pastoral theology and spiritual care approach that will be proposed is expected to broaden the scope and roles of spiritual care to assist everyone affected—directly and indirectly—by the lived experiences of schizophrenia, within the church and beyond. Countering the religious, social, and cultural sanist assumptions associated with schizophrenia, the new model will guide a more equal and empowering care process, ultimately facilitating an increase in wellbeing for everyone involved.

Methodology and Methods

My dissertation focuses on Protestant pastors' experiences with individuals diagnosed or identified with schizophrenia in the Korean church, aiming to examine two specific aspects central to their pastoral care encounters with them. First, I investigate the nature and contents of sanist theological views on the human experience labeled as schizophrenia and its relevancy to pastoral care. These views are shaped by social and religious constructs of mental illness widely shared in Korean society and the church. Secondly, I explore the diverse dilemmatic experiences faced by Korean pastors within the context of their pastoral care interactions with individuals living with schizophrenia to uncover the underlying causes of these dilemmas. These two foci of the dissertation influenced my decision to the select the following three research methods: Critical narrative inquiry integrated with the "Thinking with Theory" approach, Carrie Doehring's intercultural spiritual care approach, and Dialectical Behavior Therapy (DBT).

Many researchers adopt narrative inquiry for its advantages in studying the nuanced relationships between the experiences of research participants shared with a researcher through

stories and the broader contexts affecting the formulation and recreation of these stories. Stories reveal the values and meanings of research participants, whether these remain consistent or undergo changes between the occurrences of events and the time of narrating the narrative. Researchers also participate in this through the interpretation of the narrative.[13] The "Thinking with Theory" approach aids the interpretation/analysis process by allowing for the consideration of multiple perspectives, thereby fostering a more holistic and nuanced understanding of the narratives of the research participants.[14]

The intercultural spiritual care approach proposed by Carrie Doehring can help spiritual caregivers become aware of sociocultural contexts and their influences on the theologies that influence their caregiving practices. Intercultural approaches acknowledge differences in lived experiences, including among those with the same psychiatric diagnosis. Helping detect the subtle differences in care receivers' experiences and theologies, the intercultural approach enables caregivers to see how care receivers' beliefs, values, and practices are interrelated.[15] This awareness allows me to analyze what led my research participants' care decisions in their pastoral encounters with persons with schizophrenia in the church. It also helps explain the role that pastors' underlying beliefs and virtues played in their care interactions. Doehring's approach also guides the discovery of pastors' espoused beliefs, virtues, and practices,[16] inherent but not yet realized or facilitated.

Lastly, Dialectical Behavior Therapy gives spiritual caregivers the insights they need to make realistic, pragmatic, but also intentionally mad-affirming and inclusive spiritual care

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[13] John W. Creswell and Cheryl N. Poth, *Qualitative Inquiry & Research Design: Choosing among Five Approaches*, 4th ed. (Los Angeles: SAGE, 2018), 70.

[14] Alecia Youngblood Jackson and Lisa A. Mazzei, *Thinking with Theory in Qualitative Research: Viewing Data across Multiple Perspectives*, 1st ed. (New York: Routledge, 2012).

[15] Carrie Doehring, *The Practice of Pastoral Care: A Postmodern Approach*, rev. ed. (Louisville, KY: Westminster John Knox Press, 2015), 4-6.

[16] Doehring, *The Practice of Pastoral Care*, 187-88.

decisions from the care options deliberated on by pastoral caregivers. Seeking a synthesis between the choices representing thesis and antithesis,[17] dialectics assists people with emotional and behavioral difficulties and their therapists to choose the middle path between "change" and "acceptance."[18] The application of the dialectical principle makes spiritual caregivers' theological deliberations deeper and more effective, helping them navigate challenging dilemmas in care.

Audience

The primary audience of my dissertation is those who study or provide spiritual care to people living with mental illness and their families among Protestant Christian groups, as well as those interested in improving the quality and effectiveness of care, specifically related to various justice issues. Beyond the primary audience, this dissertation aims to appeal to caregivers from different religious backgrounds by explaining the process of constructing the religious meanings of living with and caring for people with lived experiences of mental illness, encouraging an alternative approach to caregiving inspired by Mad Studies and Feminist Studies.

The Significance of Use of Language

The nature of this research demands sensitive choice of languages that are liberative rather than oppressive. Language matters. Some languages used here to describe people's experiences are given more authority and power by the state and psychiatric discourse as if they are the only way to prescribe and define people's experiences, behaviors, and decisions without genuinely listening to and comprehending their lived experiences. My dissertation sometimes employs psychiatric terms such as schizophrenia and psychosis as diagnoses, and hallucination

[17] Marsha Linehan, *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (New York: Guilford Press, 1993), 33-34.

[18] Linehan, *Cognitive-Behavioral Treatment*, 109-10.

and delusion as symptoms, instead of using alternative terms such as "a way of being or processing that psychiatrists do not see as 'normal'" (mental illness) or "hearing or seeing what others do not see or hear" (hallucination).[19] The purpose of using these terms is to facilitate my scholarly discussion with audiences who are familiar with them, but it does not mean I endorse or comply with their use without dissatisfaction or resistance.

I value how the Mad Studies movement highlights the significance of reclaiming terms once used to belittle and degrade people with mental illness, using "refusal terms" in response to psychiatric, medical, and government terms.[20] Given this, I deliberately avoid the use of coercive, pathologizing, and sanist languages in developing arguments, except when such languages are used by and appears as quotes from my research participants during interviews. This includes terms such as schizophrenic, mentally ill, patients, mental illness, and symptoms. I use instead terms like mental distress or "having lived experience."

Definitions

Some definitions need to be clarified to aid the discussion of my dissertation. Despite their differences, pastoral and spiritual care are interchangeably used in this dissertation. Doehring defines pastoral care as caretaking duties performed in Judeo-Christian contexts, while spiritual care implies caretaking occurring in interfaith and wider religious and professional contexts.[21] While it would be more accurate to only use the term pastoral care, given the dissertation's focus on Korean Protestant pastors' experiences, the desire for it to be applicable in other contexts leads me to also use the term spiritual care.

[19] Bonnie Burstow, "A Rose by Any Other Name: Naming and the Battle against Psychiatry," in *Mad Matters: A Critical Reader in Canadian Mad Studies*, ed. Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume (Toronto: Canadian Scholars' Press, 2013), 83.

[20] Burstow, "A Rose by Any Other Name," 82.

[21] Doehring, *The Practice of Pastoral Care*, 190-91.

Sanism refers to "the systematic subjugation of people who have received mental health diagnoses or treatment" that "result in various forms of stigma, blatant discrimination, and a host of microaggressions."[22] The usage of sanism in this dissertation typically indicates the prejudicial, discriminatory, and unjust ideas and attitudes within Korean society and Korean Protestant churches that are applied to those with identifiable features of lived experience of mental distress.

Epistemic injustice is one of the phenomena of sanism, discrediting and invalidating the experiential knowledge of people who experience psychiatric diagnoses and treatments. As a form of violence, epistemic injustice is "done to people via particular worldviews or knowledge claims" to "[ignore] someone's reality from their perspective."[23] Leblanc and Kinsella highlight the significance of reevaluating and affirming the validity of the lived knowledge of psychiatrized people. Doing so is a matter of justice deeply related to their agency and power: "The subjugation of Mad persons' experiences raises questions concerning power and knowledge, in particular, what constitutes valid knowledge(s), who are the legitimate knowers and whose knowledge should count?"[24]

As defined in the dictionary, a dilemma arises when there are conflicting choices or alternatives, making it challenging to make meanings and decisions because neither option will result in a perfect and satisfactory outcome.[25] In the context of my dissertation, the term dilemma refers to moments when pastors feel stuck or faced with challenges in providing spiritual care due to conflicting values. These dilemmas often hinder or even halt pastors' proactive

[22] LeFrançois, Menzies, and Reaume, "Glossary of Terms," 339.
[23] LeFrançois, Menzies, and Reaume, "Glossary of Terms," 336.
[24] Stephanie LeBlanc and Elizabeth Anne Kinsella, "Toward Epistemic Justice: A Critically Reflexive Examination of 'Sanism' and Implications for Knowledge Generation," *Studies in Social Justice* 10, no. 1 (August 11, 2016): 60, https://doi.org/10.26522/ssj.v10i1.1324.
[25] "Dilemma," Oxford Reference. Accessed October 10, 2023. https://www.oxfordreference.com/display/10.1093/oi/authority.20110803095718683.

engagement, potentially leading to hasty decisions without thorough consideration of the underlying issues and available options.

Researcher's Location

"Why are you interested in such a topic? That's a rare experience that ordinary people may never encounter in their lives." As the question I have heard endlessly reflects, to many—particularly those residing in Korea—interest in a topic such as schizophrenia may seem unusual and irrelevant for an Asian, heterosexual, married, Christian, male, Korean international student in his 40s, currently residing and studying in the United States. Most questioners usually stop there, while some dare to go further, attempting to break my silence by concluding: you appear to be related to that rare experience.

It is no secret that every family dealing with schizophrenia has a secret to keep until it inevitably breaks to others. Since witnessing my uncle's struggles with delusions and hallucinations and learning about his life with schizophrenia during my teens, my lifelong commitment to secret-keeping began. With my grandparents and then my parents being the primary caretakers of my uncle, I was not assigned to participate in his care. Whether driven by guilt or shame for not being involved in the struggle and my continuing denial of the person who is alive and exists, mental illness has been a constant academic interest of mine, ever since I started studying theology. This puts me in a peculiar position—I feel relieved that I am doing something right and that I ought to do, yet I have been neglecting it, saving my uncle from schizophrenia and my deceased grandparents whose lives were filled with grief, remorse, and sorrow. Sarah Lund's self-reflection on her father with mental distress resonates deeply, hitting the nail on locating my deep-seated emotional motivation of doing this research:

> I also realize that there were selfish reasons why I worked with people who were homeless. I felt helpless because there wasn't anything I could do about my father's

> mental illness. I was drawn to work with the homeless (and often times mentally ill) as a way to feel closer to my father. Just as I was volunteering to help them, I knew they were helping me too. Being with the community of God's homeless people helped me form a better understanding of my life. I knew that the homeless people in San Antonio had families too, just like my father far away in Los Angeles. The families who had become estranged from their homeless and mentally ill relatives had valid reasons for doing so. Sometimes as family members we simply cannot be the ones to help them, but we need to trust that others can and will. And there were some compassionate people in L.A. who helped my father.[26]

Throughout my research, both in reviewing literature and conducting qualitative research interviews, two vivid images powerfully struck me in terms of my location as researcher: reaching a dead end and being swung on the pendulum. First, the feeling of facing a deadlock results from observing the gap between theory—pastoral and practical theological research and its sincere, promising suggestions for the churches, and practice—and the challenging, complex, and poorly structured contexts without much support provided for pastors in their practice of spiritual care. Theologically and practically well-developed arguments for the church to be inclusive and advocate for people with lived experiences of mental illness and disabilities have faced hurdles and resistance from clergy and congregations in adopting them into the ministry, as Swinton expects.[27] This is due to the combination of various contextual and contributing factors that make this task extremely challenging and seemingly impossible. There are valid points in the resistance or suspicion of pastors and church members regarding the necessity and effectiveness of the spiritual care imperative for this population, considering pastors' already burdensome ministerial tasks and their taxing contexts. During the interviews and analysis, I have repeatedly questioned whether it is right to add more tasks to the already stacked

[26] Sarah Griffith Lund, *Blessed Are the Crazy: Breaking the Silence about Mental Illness, Family, and Church* (St. Louis, MO: Chalice Press, 2014), 21-22.

[27] Swinton, *Resurrecting the Person*, 165-92.

responsibilities of pastors if I were only to demonstrate the theological significance of this spiritual care task.

The second image of the pendulum sting stems from my researcher's dilemma deeply rooted in the issue of mental illness, especially schizophrenia. Among many social issues, I personally see the debate on how to care for people with mental illness as the most sharply divided and heated, and, if I may add my impression, more emotionally charged, blaming and name-calling, fierce, and non-negotiable than any other debates. This is well evident in the reactions of activists with lived experience of psychiatric treatments towards the passing of the long-time mental health family advocate, DJ Jaffe. Devoting his life to prioritizing immediate, involuntary, mandated psychiatric treatment for people with severe mental illness over all other mental health reform and liberation efforts, Jaffe's death drew resentful and ambivalent emotional reactions from those who disagreed with his positions.[28]

My research focus up until the midpoint of the doctoral program and my clinical training as a pastoral counselor had aligned with Jaffe's stance, as I also highly valued and prioritized medical/psychiatric treatment for populations. I acknowledged that medical and psychological issues are central to their lives due to the debilitating impacts and excruciating pains experienced by both the individuals and their families. Pursuing equal social and economic treatment and opportunities for them results in favorable recovery progress, which can be supported by the faith community.

[28] Briana Gilmore, "An Obituary for My Colonizer: Reflections on the Legacy of DJ Jaffe," *Mad In America*, September 13, 2020, https://www.madinamerica.com/2020/09/an-obituary-for-my-colonizer/; Pete Earley, "Reader Writes D. J. Jaffe Was No Friend to 'Those of Us with Mental Health Concerns.,'" *Pete Earley*, August 31, 2020, https://www.peteearley.com/2020/08/31/reader-writes-d-j-jaffe-was-no-friend-to-those-of-us-with-mental-health-concerns/.

Through the various voices raised upon Jaffe's death, I was introduced to disciplines such as Mad Studies and Critical Mental Health. These new perspectives enable me to see the injustices and oppressions deeply entrenched in the lives of people diagnosed and treated by psychiatry. The disciplines scathingly denounce the psychiatric and medical discourse that has dominated the representation and treatment of people with lived experience of mental illness, discrediting their lived knowledge and power, while remaining oblivious to the sanist ideas, beliefs, and practices shared in society. This learning leads me to the initial conclusion that the medical model of mental distress cannot resolve the complicated issues of oppression faced by these individuals, even despite efforts to fight against mental illness stigma.

The debate involves many parties with high stakes, including diverse groups of people with lived experiences with different foci and orientations—such as the Mental Health Consumer/Survivor movement, Neurodiversity movement, the Hearing Voice movement, Mad Studies, their families and relatives, and mental health professionals in various positions of pro, critical, reformist, and anti-psychiatry. Listening to the voices on two poles—treatment and justice—has made me feel like I am endlessly swung on a pendulum. As every position has its own validity, priorities, and implications regarding human mental distress, it no longer matters who is right or wrong. This experience inevitably led me to search for a both-and approach, instead of either-or—to be balanced, realistic, and pragmatic in determining what would be more beneficial, context-wise, resource-aware, and achievable spiritual care goals to be set for both spiritual caregivers and care receivers with lived experience of schizophrenia.

Scope and Limitations

The primary scope of my dissertation embraces the caregiving experiences of people with schizophrenia, with specific regard to their theological narratives. Drawing on mad-affirming

approaches to the experiences of schizophrenia, which validate the agency, capacities, and dignity of people diagnosed with schizophrenia, this dissertation explores theological and spiritual meanings that align with these alternative approaches. Discovering the unexamined aspects of living with schizophrenia leads to further investigation of the roles, meanings, and dynamics of caring that will, in turn, offer insight into how to forge a more empowering and holistic pastoral theology for theory and practice.

With some concern about any possible misunderstanding of my research argument, I want to clarify the intention behind my attempt to theologically reconstruct experiences of schizophrenia and how it is cared for. My intention is not to dismiss or minimize the responsibility the church and society have to proactively assist people with schizophrenia, their families, and their caregivers. Regardless of their position regarding ethical issues in the treatment of schizophrenia, it is the consensus among scholars and activists that the burden of care should not be left solely to the family of a person with schizophrenia. Due to the limits of this research, although I anticipate that my proposal for a new theological understanding will contribute to the continuing discussion of justice for those who give and receive care, this dissertation cannot contribute to a complete discussion of the part played by society in creating and providing adequate resources and systems to support those involved—including creating a better treatment for all caregivers.

Contributions

My doctoral research intends to make contributions to the field of pastoral and practical theology by examining the realities of the spiritual care of those with schizophrenia and developing the theological grounds for providing more just, liberative, and holistic spiritual care to the affected populations and their caregivers. I expect that my critical pastoral theological

argument in support of the anti-sanist, mad-affirming, and dialectical approach to care for people with schizophrenia will devise a liberative Christian theological anthropology with this lived experience by reconsidering the concepts of human agency and capacities. The research is designed to facilitate the advancement of spiritual care for people with schizophrenia by rethinking the nature, values, challenges, and limits of caring relationships for individuals with conditions that necessitate dependency on others. It also strives to be aware of and address injustices while exploring unfulfilled potentials within the care contexts.

My dissertation argues for spiritual care to expand the range of its tasks, challenge sanism, and adopt an alternative approach that embraces mental illness as human diversity in the Korean Christian Church context by acknowledging the differences among impairment, distress, and disability entailed within madness. Since Mad Studies has been criticized for its overrepresentation of Eurocentric heterosexual voices and lack of diversity in race, ethnicity, and gender,[29] my investigation of sanism and proposal for an alternative Christian theological view of madness in the Korean Christian church will diversify the movement.

Finally, given the similar realities of other forms of human dependency caused by specific cognitive, affective, or behavioral conditions that accompany distress, crisis, and demand, I hope my dissertation provides inspiration and insight into developing a liberative, context-informed, practical theological approach to mental illness as human experience. It aims to revamp the theory and practice of spiritual care for individuals experiencing various expressions of mental illness and disabilities.

Outline of Dissertation Chapters

Chapter 1 – Introduction

[29] Peter Beresford, "'Mad,' Mad Studies and Advancing Inclusive Resistance," *Disability & Society* 35, no. 8 (2020): 1339-40, https://doi.org/10.1080/09687599.2019.1692168.

This chapter provides an outline of the other chapters and presents the argument for why it is important to propose an alternative theological understanding of schizophrenia for spiritual care of the affected population by summarizing the problems within the two prevalent models of understanding mental illness in the Korean church. Both models are rooted in the sanist culture that fundamentally denies the full humanity of people with schizophrenia and discredits their agency and capacities. The chapter provides an overview of the research briefly explaining significant literatures, research methodologies, and design for how to conduct qualitative research interviews and analyze data. It also describes the dissertation's primary audience, limitations and scopes, contribution, key research issues (including definitions and languages), and discusses the researcher's context and how this has impacted their research.

Chapter 2 – Literature Review

This chapter reviews existing literature on 1) psychiatric understandings of the phenomenon of schizophrenia; 2) the reality of living with the diagnosis in Korean society and church; 3) pastoral theology and counseling approaches to the role of religious leaders and communities in caring for individuals with this lived experience in the church; 4) critical mental health and mad studies as new movements in the field; 5) feminist studies of care for human dependency; 6) disability theology around mental disabilities; 7) Carrie Doehring's intercultural spiritual care approach; and 8) Dialectical Behavior Therapy (DBT). The review serves as the ground from which to critically examine, deconstruct, and reconstruct the caregiving experiences of pastoral/spiritual caregivers of people with schizophrenia, and their theological meanings, within the context of Korean Protestant Church.

Chapter 3 – Methodology and Methods

This chapter discusses the research methodology and methods employed in my dissertation. Critical narrative inquiry as a qualitative research method will be adopted to collect and interpret the narratives of seven Korean pastors who encountered and cared for individuals with lived experiences of schizophrenia in the churches they served. The chapter explains the design of the research project in implementing individual interviews, collecting the data, and critically analyzing narratives, drawing on Alecia Jackson and Lisa Mazzei's thinking with theory approach.

Doehring's intercultural spiritual care approach guides the co-creation process of theologically reconstructing the fragmented and life-limiting sanist embedded theology, and transforming it into well-integrated, life-giving intentional theology. The intercultural approach assists the process of examining the various socio-cultural and theological influences on the interviewees' embedded theology and cultivating creative and constructive theological beliefs and values to empower and liberate those affected by schizophrenia.

The dialectics principle of Dialectical Behavior Therapy (DBT) aids in the process of identifying opposing choices existing in dilemmatic situations. It helps individuals develop strategies to approach these situations with increased awareness, emotional control, and effective decision-making. For the pastors who faced dilemmic situations during their provision of spiritual care to individuals with lived experiences of schizophrenia, DBT allowed them to reach a synthesis that both validated their beliefs and values and enabled them to choose realistic and mad-affirming and liberative care decisions. Sharing their emphasis on the researcher/practitioner's role in actively participating in the co-creating meaning process, the methodological approaches I adopted make it unavoidable to disclose my researcher's location.

Chapter 4 – Stories and Expectation Versus Reality

This chapter provides reports on interviews with seven Korean pastors and their caregiving interactions with individuals with schizophrenia in the churches they served. It presents the research participants' narratives of their pastoral encounters with people experiencing schizophrenia and their evaluations of these experiences, along with relevant understandings. In particular, the latter depicts the similarities and discrepancies among the pastors' views on schizophrenia, perceived images of people living with schizophrenia in Korean society and the church, as well as their beliefs, values, and expectations of pastoral care for those with specific lived experiences. This is followed by a list of the pastoral care they conducted during actual interactions.

Chapter 5 – Dilemmas in Pastoral Care of People with Schizophrenia

In this chapter, the specific focus is placed on the dilemmatic moments faced by the research participants while providing spiritual care to the identified individuals. Depending on the nature and contents of the conflicts and struggles confronted or observed in the spiritual care of these individuals, dilemmas are categorized into seven types: 1) Personal; 2) Pastoral; 3) Relational; 4) Theological; 5) Ethical; 6) Cultural-Epistemic; and 7) Practical.

Chapter 6 – Thinking with Sanism

This chapter employs the analytical approach of thinking within the concept of "sanism" in critically re-reading the interviewees' dilemma narratives discussed in Chapter 4. Embedded in the contexts of Korean pastors and the Korean church's embrace of people with schizophrenia, different injustice issues regarding the individuals' lived experiences give rise to dilemmatic and negative experiences in the pastors' interactions. The chapter unravels the relationships between negative, challenging, and conflicting pastoral care experiences and the oppressive and unjust

sanist views held by the pastors, congregations, the church as a faith community, and Korean society.

Chapter 7 – Thinking with Dialectics

Applying the same methodological analytic process, this chapter explores how the dialectical thinking can interpret Korean pastors' narratives about dilemmatic experiences they encountered while providing spiritual care for individuals with schizophrenia. This analysis helps illuminate theological beliefs, values, and practices that may exist but are not explicitly acknowledged and chosen in the pastors' practice during dilemmatic care situations. However, the ultimate aim of this chapter is to assess the validities of both chosen (thesis) and unchosen (anti-thesis) caring options, ultimately identifying middle options that synthesize and address the beliefs and merits of both choices.

Chapter 8 – Conclusion

Based on the results of the discussion, in the final chapter, Carrie Doehring's intercultural spiritual care model is revisited to refine the spiritual care model for people with schizophrenia. This revision aims to contemplate the needs, challenges, burdens, and limitations of spiritual care for the population while embracing unconventional, mad-affirming beliefs, values, and potentials in addressing the diverse experiences of individuals labeled as schizophrenic. As an example of how to plan intercultural spiritual care using the process of "liberative spiritual integration," Doehring presents three phases of the care process, based on the works of Judith Herman and Marie Fortune about care for trauma and violence.[30] The following features will be discussed in the revision of intercultural spiritual care: 1) establishing safety for both caregivers and care receivers, while building trust by validating the care recipients' lived experiences of

[30] Doehring, *The Practice of Pastoral Care*, 173-86.

schizophrenia through the lens of epistemic creativity; 2) working with various losses and grief accompanied by the lived experiences of schizophrenia in the sanist world, acknowledging and fostering communal accountabilities and setting realistic expectations for those with the lived experience; and 3) reconnecting with the goodness of life, community, self, and God through religious/spiritual experiences and resources tailored to their capabilities and lived experiences, which empowers individuals to progress along the path of recovery. The concepts of epistemic creativity and dialectics are employed here to revise and expand the spiritual care model into one that guides an anti-sanist, mutually empowering, and practical process of spiritual care.

Chapter 2

Literature Review

Introduction

Labeled as severe mental illness (SMI), schizophrenia has been considered a type of disability that leads to social disconnection, isolating individuals from others, irrespective of their direct or indirect experiences. Unlike other physical illnesses, such as cancer and heart disease, mental illnesses are less accepted and are subject to unfair treatment by people in Korean society and the Korean church. Due to the lack of understanding among congregations and clergy regarding the lived experience of mental illness, coupled with religious, social, and cultural stigmas against this identified group, people living with schizophrenia and their families endure passive-aggressive, covert—if not hostile and overt—forms of judgment, neglect, and alienation, which Robert H. Albers calls "a conspiracy of silence."[1]

Among the many reasons mental illnesses are treated differently than physical illnesses or other disabilities is the deep-rooted issue of sanism in society. While the term "sanism" is less popularized than its counterpart, "stigma," it sheds light on the oppressive and inhumane dimensions of unjust treatments, discrimination, and oppression faced by individuals with lived experiences of mental illness, both from mental health professionals and non-professionals. Sanism includes the various kinds of injustices existing in the context of the Korean church, as evidenced by its reluctance to include people diagnosed with a mental illness and those who have been psychiatrized. In particular, the concept of epistemic injustice shows how people with schizophrenia are prevented from being a part of and practicing their faith in the faith

[1] Robert H. Albers, "Introduction, First Edition," in *Ministry with Persons with Mental Illness and Their Families*, 2nd ed., ed. Robert H. Albers, William Meller, and Steven D. Thurber (Minneapolis: Fortress Press, 2019), xii.

community. This level of epistemic injustice is widespread in society, including religious communities.

To understand the reality of living with schizophrenia in Korean society and the church, I begin by examining the discourse considered the most authoritative, yet not always exhaustively explainable and reliably persuasive in defining and controlling people's experiences: psychiatry. I investigate how psychiatry defines the experiences of individuals diagnosed with schizophrenia and the roles assigned to faith communities, specifically Protestant churches. This exploration sheds light on how psychiatric discourses prescribe descriptions of schizophrenia as categorical norms, thus limiting people's lived experiences to mere psychiatric symptoms and impeding religion's potential contribution. It is followed by a review of the Pastoral Theology, Care, and Counseling (PTCC) literature, which asserts that the clergy, congregations, and the Christian church as a whole can enhance their commitment to the wellness, empowerment, and liberation of individuals with lived experiences of schizophrenia and their families. This consideration involves religious/spiritual teachings, values, resources, and missions as motives.

I then introduce a new movement that has emerged to validate the power and knowledge of lived experiences of mental distress: Mad Studies. Mad Studies demonstrates how the psychiatrization of society and the dominant rise of psychiatric discourse deprives people with lived experiences of mental distress, including schizophrenia, of rights and powers when it comes to describing and affirming their experiences and making choices related to both treatment and life in general. Along with a related discipline, Critical Mental Health, Mad Studies aims to address the issues of sanism, especially the epistemic injustice applied broadly to discriminate against and oppress groups identified and defined by their psychiatric diagnoses. Two critical disciplines, feminist studies and disability theology, elucidate various issues of

justice relevant to marginalized groups in society, particularly those with mental disabilities. This includes relational justice, epistemic justice, distributive justice, care justice, and economic justice. This exploration aids this dissertation's goal of comprehending the realities of people with schizophrenia. Finally, the intercultural spiritual care approach and Dialectical Behavior Therapy (DBT) are briefly discussed to provide the reader with an understanding of their theoretical foundations, as they are used as research methods for the dissertation.

Understanding Schizophrenia

How Psychiatry Defines Schizophrenia

Schizophrenia is a psychiatric diagnostic term which refers to an idiosyncratic combination of distinct cognitive, emotional, behavioral, psychological, and related human experiences. The experiences prescribed by psychiatry as symptoms include hallucination, delusion, and disorganized speech or behavior, categorized as positive symptoms, along with negative symptoms that include avolition, apathy, and social withdrawal.[2] According to psychiatry, as part and/or the result of psychiatric symptoms and the side effects of psychotropic medications, people with lived experiences of schizophrenia have struggled with prolonged cognitive, affective, and social impairments and psychomotor dysregulation.[3] A notable change in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was to drop the classification of five subtypes of schizophrenia listed in the previous edition and adopt the term "spectrum." This change indicates that it is increasingly recognized that there are varying degrees of differences in the manifestation of an individual's experience of

[2] American Psychiatric Association, "Schizophrenia," in *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*, 5th ed. (Washington, DC: American Psychiatric Association, 2013), 99-100.

[3] Substance Abuse and Mental Health Services Administration, "Table 3.22: DSM-IV to DSM-5 Schizophrenia Comparison," in *Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health* (Rockville, MD: Substance Abuse and Mental Health Services Administration [US], 2016), 123-27, https://www.ncbi.nlm.nih.gov/books/NBK519704/table/ch3.t22/.

schizophrenia, from form to duration, severity, course, progress, and aftermath.[4] This change also signifies that the experience of living with schizophrenia should not be essentialized and generalized into psychiatric or psychological descriptions.

Although the direct causes of schizophrenia are not yet clearly understood, researchers concur that it frequently occurs as the result of an interaction of genetics, neurological causes, and environmental stimuli.[5] Those who uphold the bio-psychiatry model assert that schizophrenia is a brain disorder primarily attributed to biological factors, rather than other influences. This emphasis counters theories that hold the affected individual or their families accountable for the condition.[6] Classified as one of the severe mental illnesses (SMI), schizophrenia refers to the mental, behavioral, or emotional condition that entails life-long "serious functional impairment that substantially interferes with or limits one or more major life activities."[7] An estimated 250,000 to 500,000 people in South Korea,[8] 1.5 million in the US,[9] and 24 million worldwide, have been diagnosed with schizophrenia, comprising less than 1 percent of the entire world population.[10] In addition to the distress caused by the illness's debilitating symptoms and impairments, the negative social perception and stigma of schizophrenia imposes social suffering in the form of social isolation and marginalization, which

[4] James R. Morrison, *DSM-5 Made Easy: The Clinician's Guide to Diagnosis* (New York: Guilford Press, 2014), 65.

[5] "Schizophrenia," National Alliance on Mental Illness (NAMI), accessed August 10, 2023, https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Schizophrenia.

[6] Torrey, *Surviving Schizophrenia*, 118-25.

[7] "Mental Health and Substance Use Disorders," Substance Abuse and Mental Health Services Administration (SAMHSA), accessed August 10, 2023, https://www.samhsa.gov/find-help/disorders.

[8] "Johyeonbyeong," National Center for Mental Health, accessed August 10, 2023, https://www.mentalhealth.go.kr/portal/disease/diseaseDetail.do?dissId=26.

[9] "Quick Facts and Statistics About Mental Health," Mental Health America, accessed August 10, 2023, https://mhanational.org/mentalhealthfacts.

[10] "Schizophrenia," World Health Organization (WHO), accessed June 15, 2023, https://www.who.int/news-room/fact-sheets/detail/schizophrenia.

impedes treatment and recovery.[11] Much non-scholarly literature, including memoirs of individuals with lived experiences of schizophrenia or their family members, serves to inform the public about the experience of schizophrenia, educating readers about the various challenges faced by individuals with this condition and their families, while also raising awareness of the need for public assistance and social acceptance of this group.[12]

How Psychiatry Understands the Roles of Pastors and the Church

Various groups in the field of psychiatry adopt different stances toward religious groups and ministers, broadly categorizing them as allies or foes. Due to the relatively high number of individuals seeking help from religious leaders for their mental health issues, these leaders are appreciated for their accessibility and availability. Simultaneously, some are criticized for retaining care seekers too long for religious or spiritual approaches instead of promptly referring patients to medical professionals.[13]

The group of psychiatrists who considers religion a useful ally encourages faith communities, including Christian churches, to participate in caring for populations with mental health issues and their families, utilizing the communities' relational, communal, and spiritual resources. Literature is abundant from psychiatrists and religious scholars that support psychiatry's view that the role of religion is to assist people in adhering to their psychiatric and

[11] Gil Dov Hoftman, "The Burden of Mental Illness Beyond Clinical Symptoms: Impact of Stigma on the Onset and Course of Schizophrenia Spectrum Disorders," *American Journal of Psychiatry Residents' Journal* 11, no. 4 (May 4, 2017), https://doi.org/10.1176/appi.ajp-rj.2016.110404.

[12] To name a few, Elyn R. Saks, *The Center Cannot Hold: My Journey through Madness* (New York: Hyperion, 2007); Ron Powers, *No One Cares About Crazy People: The Chaos and Heartbreak of Mental Health in America* (New York: Hachette Books, 2017); Miriam Feldman, *He Came in with It: A Portrait of Motherhood and Madness* (Nashville: Turner, 2020); Mindy Greiling, *Fix What You Can: Schizophrenia and a Lawmaker's Fight for Her Son* (Minneapolis: University of Minnesota Press, 2020).

[13] Craig Rennebohm and David Paul, *Mental Health Ministry: An Introduction*, Companionship Series (Seattle, WA: Mental Health Chaplaincy, 2012), 9-11.

psychopharmacological treatments during treatment and recovery.[14] One noteworthy example is the manual published for religious communities from a collaboration between the American Psychiatric Association (APA) and faith leaders who work as mental health advocates.[15] According to the manual, pastors and churches can play significant roles in the early detection of mental illness, proactive referrals, and the creation of a welcoming, non-stigmatizing, and supportive environment for those experiencing mental health issues.[16]

Writings aligned with the position of the group espousing dominant psychiatry's authority give the subtle impression that religion and spirituality play only auxiliary roles during care and are meant to serve psychiatry. This perspective becomes more evident in the context of schizophrenia, where psychiatric guidance offered to pastors centers on a singular role: the immediate referral of individuals displaying psychotic symptoms, such as hallucinations, delusions, or socially unacceptable erratic expressions or behaviors, to mental health professionals.[17] The counsel to limit the roles of pastors is grounded in reasonable concerns drawn from history, especially the long history of clergy's lack of knowledge about schizophrenia and equating the condition with spiritual, moral defects upon sanist/ableist notions of human experiences. These understandings have often led to the mismanagement, maltreatment, and even inhumane torture of individuals exhibiting symptomatic behaviors, causing them additional harm beyond treatment disruption.[18]

Going back to the aforementioned APA manual for faith leaders, like other writings from

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[14] American Psychiatric Association, *Mental Health: A Guide for Faith Leaders* (Arlington, VA: American Psychiatric Association Foundation, 2016); Cynthia Franklin and Rowena Fong, eds., *The Church Leader's Counseling Resource Book: A Guide to Mental Health and Social Problems* (Oxford: Oxford University Press, 2011); Torrey, *Surviving Schizophrenia*.

[15] American Psychiatric Association, *Mental Health.*

[16] American Psychiatric Association, *Mental Health*, 15-19.

[17] American Psychiatric Association, *Mental Health*, 16.

[18] Maurianne Adams, Lee Anne Bell, and Pat Griffin, *Teaching for Diversity and Social Justice*, 2nd ed. (New York: Routledge, 2007), 421-36.

similar perspectives, the manual does not delve deeply into the post-acute/active stage of individuals facing mental health challenges, offering only a broad overview of what pastors and churches can do.[19] Specifically, publications from these writers provide relatively less content on holistically understanding the issues, needs, and wants of people with lived experiences of schizophrenia during the residual phases of their recovery compared to the prodromal and active episodes.[20] This can be justified by their main purpose, which is to provide faith leaders and lay congregations, who may lack education and training in understanding mental illness from a psychiatric perspective, with concise information and guidelines on directing people when they detect urgent or critical signs of harm caused by mental illness. Furthermore, this absence may create opportunities for clergy, ministers, lay leaders, and other congregants to develop their theology and practices in a way that contributes to the lives of those who recover and heal from mental health crises by exploring relevant themes and meanings grounded in people's lived experiences of mental distress.

While I do not entirely oppose the guidelines of certain psychiatrists' groups for religious leaders and communities, considering the historical context and the risks involved in interacting with individuals exhibiting acute psychosis, the narrowly defined roles for faith leaders concern me because they seem to restrict the scope of religion/spirituality's potential contributions to the lives of people with mental illness.

Reducing the primary roles of religious communities to the referral to medical/psychiatric treatments, especially in cases of severe mental illnesses like schizophrenia, may suggest the irrelevance of religion/spirituality to the lives of people experiencing mental distress. This

[19] American Psychiatric Association, *Mental Health,* 15.

[20] American Psychiatric Association, *Mental Health*; Franklin and Fong, eds., *The Church Leader's Counseling Resource Book*; Albers, Meller, and Thurber, eds., *Ministry with Persons with Mental Illness and Their Families*.

attitude derives from the premise that mental illness is an exclusive psychological/psychiatric phenomenon, distinct from religious/spiritual experiences. It is based on some psychiatrists' suspicion of the potential harm religion/spirituality can pose, observing throughout history the attempts to link an individual's religious/spiritual conditions to their mental illness and the inhumane approaches to cure that resulted.[21] This leads to the quick-fix answer: medicalizing the phenomena of mental distress.

Will naming mental illness as a "purely medical experience" solve all the stigmas around mental illness in the church? My answer is no. Although this will be discussed further in the section on Critical Mental Health and Mad Studies, it is essential to be aware that theology can play a substantial role in fighting against and eradicating stereotypes, prejudices, and discriminations associated with the notion of "mental illnesses," including schizophrenia.

Furthermore, even when referring individuals to medical professionals as a form of spiritual care, the work of theological reasoning can provide an important grounding. The course of providing spiritual care to someone's lived experiences of mental illness includes an inevitable interplay between the process of theological constructions and other meaning- and decision-making processes. It is only a matter of time, whether it happens before, during, or after a crisis event, that those involved in the care—pastoral/spiritual caregivers, individuals with schizophrenia, and their families and communities—revisit their theologies regarding the experiences, as they demand theological interpretations of what happened to them and why. Fortunately, I see meaningful efforts being made to develop theological constructions of mental distress with a less pathologizing and more empathetic and compassionate religious/spiritual

[21] Stephen P. Hinshaw, *The Mark of Shame: Stigma of Mental Illness and an Agenda for Change* (New York: Oxford University Press, 2007), 122-25.

attitude, even if I may not agree with all of their theological stances.[22]

This also applies to another role assigned to faith leaders: educating congregations about mental health. It is essential and beneficial, but the significance of integrating mental health education with religious/spiritual teachings and practices cannot be stressed enough, given the contexts of faith communities. Religious leaders and theologians hold incomparable expertise and capacity for this task compared to other professionals. For example, in alignment with psychiatry's emphasis on public education, the APA manual emphasizes the importance of educating the congregation about mental health in partnership with mental health professionals.[23] The manual further points out that mental health education is crucial in creating an inclusive community for those with mental health issues: "Boundaries regarding the range and effect of unconventional behaviors should be clearly understood by all, especially when a congregation seeks to be welcoming and inclusive."[24] However, I suspect that descriptions from a solely psychiatric/medicalizing point of view are insufficient to accomplish this challenging goal of becoming an inclusive church. These recommendations suggest to me that what people lack mental health knowledge about the lived experiences of individuals with schizophrenia, may cause them to misunderstand these individuals, leading to inappropriate responses or treatments or even to withdrawal due to fear or confusion. The statement holds only a partial truth though. There is another layer to explore regarding the church's role in caring for those experiencing mental illness.

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[22] To name a few, Matthew S. Stanford, *Madness & Grace: A Practical Guide for Pastoral Care and Serious Mental Illness*, Spirituality and Mental Health (West Conshohocken, PA: Templeton Press, 2021); Amy Simpson, *Troubled Minds: Mental Illness and the Church's Mission* (Downers Grove, IL: InterVarsityPress, 2013), Kindle; Stephen Grcevich, *Mental Health and the Church: A Ministry Handbook for Including Children and Adults with ADHD, Anxiety, Mood Disorders, and Other Common Mental Health Conditions* (Grand Rapids, MI: Zondervan, 2018).

[23] American Psychiatric Association, ed., *Mental Health*, 15.

[24] American Psychiatric Association, ed., *Mental Health*, 19.

I argue that the task of cultivating an inclusive and empowering environment in the church, which implies actively fighting to eliminate stigmas against mental illness, requires the thorough theological examination of various dimensions of all lived experiences of mental illness, specifically schizophrenia, rather than constraining their experiences to a singular dimension or nature or essentializing their "symptoms." Theologians and spiritual caregivers can help people with schizophrenia explore the realities, issues, struggles, adversities, and even unforeseen benefits and potentials in their lives, in conjunction with their theology related to their lived experiences. One example is finding and utilizing religious and spiritual resources to enhance their wellness and agency.[25]

However, in my research, I observed a lack of exploration into the potential contributions of spiritual care in providing guidance during the stages of healing and recovery in the literature that adopts the biomedical psychiatry model stance. This gap could potentially be addressed by religion or spirituality, but no explicit suggestions are found. The absence of an explanation regarding the religious/spiritual meanings and perspectives of God, faith, suffering, and healing suggests that religious communities, which have established their own theories for living a happy and thriving life, even in the face of intermittent or chronic adversities or hardships, could make a significant contribution. The spiritual aspects of healing and recovery from schizophrenia, or living with schizophrenia, have the potential to reshape people's understanding of wellness and even social and cultural norms. This will be further discussed in the Mad Studies section.

Living with Mental Disabilities in the Korean Society and Church

> The history of the struggle of people with mental disabilities is a history of violence inflicted upon them, in the name of religion, social welfare, and medical care. Since the era of Japanese occupation of Korea, the paradigm of "incarceration" of people with

[25] By the phrase "when allowed and available," I mean that these tasks are not always available to all individuals living with schizophrenia, nor can they be approached in the same way for everyone with lived experiences of schizophrenia.

> mental disabilities remained firmly in place. The state always hid behind it. Irresponsibility and neglect were another name for state violence. Now, the mental health paradigm needs to shift from isolation to community rehabilitation and integration. This is the sole responsibility of the state.[26]

The history of people with mental disabilities in South Korea parallels that in other parts of the world. Various statistics reveal the harsh realities faced by this group, including having the longest number of hospital inpatient days in relation to other countries in The Organization for Economic Cooperation and Development (OECD).[27] Stigmas against mental illness, including schizophrenia, have been exacerbated by mass media's reporting of crimes committed by individuals with a history of mental illness.[28] Surveys show that schizophrenia is the most stigmatized and feared mental illness.[29] Inhumane and brutal treatment of them persisted even into the late 20th century.[30] The Korean church is no different from Korean society as a whole when it comes to stigma and discrimination against those experiencing mental illness.[31]

Despite the grim prospects for people with mental disabilities, some promising efforts are being made. Memoirs and personal narratives of individuals sharing their own or their loved ones' lived experiences of mental illness, including schizophrenia, are more common and better

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[26] Chae-jung Paek, *Yŏgi uri ka itta: Taehan min'guk chŏngsin changaein sunansa* [We are here: The history of the suffering of people with mental disability in Korea] (Seoul: Kŏngang Midiŏ Hyŏpdong Chohap, 2020), 14. English translation is mine.

[27] Paek, *Yŏgi uri ka itta*, 245.

[28] Paek, *Yŏgi uri ka itta*, 179-80.

[29] Paek, *Yŏgi uri ka itta*, 180.

[30] Paek, *Yŏgi uri ka itta*, 72-116.

[31] Munyeong Nam, "Sin-eun muneunghajiman widaehaeyo. Uri gotong-eul gyeongcheonghajanayo" [God is incompetent but great. Because God listens to our pain], 73-84; Youngseok Oh, "Jeongsinjilhwaneun siljonjeok apeum, wirohago an-a jwoya" [Mental illness is an existential pain. We need to comfort and hold the people], 360-72; Jikhan Goh, "Ireohge salaganeun saramdo han myeongjjeum-eun isseoya haji Anhneungeos-neunga" [Shouldn't there be at least one person who lives like this], 373-90, in *Maeum-eul geotda: Gotong-e daehaeseo eotteohge malhal geos-inga* [Walk the mind: How to Talk About Suffering], ed. Jongeon Park (Seoul: Paidon, 2023).

publicized than they were in the past.[32] Additionally, interests in peer support and mental health care reform movements have grown in Korea, which offers hope for improving the current status of people with mental disabilities.[33] Meaningful and significant efforts to validate and incorporate the lived experiences of mental illness into the realms of theological education and church ministries, with the goal of developing a more resonant and authentic theology and practice for people with mental disabilities and their families, have garnered increased attention and support.[34]

Shame

Sanist/stigmatizing views toward people with mental illness originated from premodern, unscientific, inhumane, anachronistic, and dichotomic ideas about mental illness.[35] Although many of those ideas have been debunked by scientific discoveries on the nature of mental illness and education, the sanist/stigmatizing views continue to have an insidious and extensive impact on the public and society. Psychologist Stephen Hinshaw adduces that the scientific model of mental disorders and empirical evidence alone is not enough to change mental illness stigma because "views about mental disorder and disturbed behavior have emanated as much from philosophy, history, and cultural mores as from scientific findings."[36]

Shame is one of the emotional struggles involved in facing stigma against schizophrenia.

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[32] Kwanhyeong Lee, *Bauel-ui gasi: Naneun johyeonbyeong hwanjada* [Paul's thorn: I am a patient with schizophrenia], rev. ed. (Seoul: Oktabbang Production, 2020); Mok-woo Park, "Johyeon, geu isang-ui salm" [Life beyond schizophrenia], in *Jilbyeong-gwa Hamkke Chumeul* [Dancing with illness], ed. Jo-Han Jin-hui, 88-151 (Paju, Gyeonggi-do: Doseo Chulpang Pureunsup, 2021); Haneui Lee, *Naye johyeonbyeong samchon: Eoneu jeongsinjilhwan dangsaja-wa gajog-ui oraen geojitmalgwa bukkeureoume gwanhayeo* [My uncle with schizophrenia: The long history of lies and shame in one individual with mental illness and his family] (Goyang, Gyeonggi-do: Amondeu, 2023).

[33] Paek, *Yŏgi uri ka itta*, 208-19.

[34] Tae Hyun Ryu, "Suggesting Mutually Supportive Pastoral Care for People with Schizophrenia and Their Families in the Korean Church: A Grounded Theory and Practical Theology of Hospitality Approaches," DMin diss., (Claremont School of Theology, 2019).

[35] Hinshaw, *The Mark of Shame*, 122-25.

[36] Hinshaw, *The Mark of Shame*, 155.

One definition suggests that two different kinds of shame can occur depending on contexts: "[Interpersonally,] shame is the emotion associated with the humiliating revelation of personal failure to another. Intrapsychically, shame is felt when the individual painfully experiences a discrepancy between the actual self and the ideal self."[37] Clinical psychologist Patricia A. DeYoung defines shame as "an experience of one's felt sense of self disintegrating concerning a dysregulating other. Chronic shame develops when many repetitions of such shame experience form a person's lifelong patterns of self-awareness and response to others."[38] Because of the negative evaluation of self and the sense of detachment, thus, shame eventually leads to a sense of "inferiority" and "social withdrawal."[39] Furthermore, theological explorations of Korean people's experiences of being wounded and sinned against, and consequent shame, imply that shame experienced within a community due to stigma can substantially and negatively affect a person's whole being, including at the theological level.[40] In line with these definitions, the research finding that Koreans with psychiatric illnesses who have deeper insights into their illness possess more internalized stigma against mental illness shows how stigma can trigger shame in those who live with the illness.[41]

Limiting the context to the Korean and Korean American church, much research conducted in Korean and Korean American settings implies that shame is what discourages

[37] Nancy L. Talbot, "Unearthing Shame in the Supervisory Experience," *American Journal of Psychotherapy* 49, no. 3 (Summer, 1995): 339. https://doi.org/10.1176/appi.psychotherapy.1995.49.3.338.

[38] Patricia A. DeYoung, *Understanding and Treating Chronic Shame: A Relational/Neurobiological Approach* (New York: Routledge, 2015), 18.

[39] Beth Angell, Andrea Cooke, and Kelly Kovac, "Forst-Person Accounts of Stigma," in *On the stigma of mental illness: practical strategies for research and social change,* ed. Patrick W. Corrigan (Washington, DC: American Psychological Association, 2005), 70-71.

[40] For a more detailed discussion, see Andrew Sung Park, *From Hurt to Healing: A Theology of the Wounded* (Nashville: Abingdon Press, 2004).

[41] Yeon-Jeong Shin et al., "Self-perceived cognitive deficits and their relationship with internalized stigma and quality of life in patients with schizophrenia," *Neuropsychiatric disease and treatment* 12 (June 16, 2016): 1411-17, https://doi.org/10.2147/NDT.S108537.

people from openly sharing and seeking help for their own or their family's mental illness.[42] The concept of saving face is utilized by various research on Korean cultural experiences to understand shame culture in Korea. Face-saving can be defined as "individuals' desire to maintain their social image, social values and social capitals influenced by their performance and specific social roles," which imposes strong group or community pressure on individuals, especially in a collective culture.[43] Researchers approach the concept of face-saving with different perspectives to explain how Koreans experience shame in relation to and interaction with the group and community to which they belong: failure to save face as part of maintaining psychosocial equilibrium,[44] as keeping individual's and family's honor secured by projecting success,[45] and as conforming to norms that preserve homogeneity.[46] Studies of shame in the Korean cultural context show how mental illness—as the expression of emotions and behaviors, which look to others and the community as deviant or discordant, and weak or inferior—is linked with and perceived as oneself losing face, or that of the family, or the group to which one belongs. With regard to mental illness and shame that is created from one's self-evaluation, one research study presents a relevant analysis that the traditional Confucian values equating mental disorders as an individual's internal problems has unfortunately led people to avoid treatment

[42] See Hochang B. Lee et al., "Improving Access to Mental Health Services for Korean American Immigrants: Moving Toward a Community Partnership Between Religious and Mental Health Services," *Psychiatry Investigation* 5, no. 1 (2008): 14, https://doi.org/10.4306/pi.2008.5.1.14; M. Han et al., "Mental-illness stigma Among Korean immigrants: Role of culture and destigmatization strategies," *Asian American Journal of Psychology* 8 (2017): 134–41, https://doi.org/10.1037/aap0000074; Pearl J. Park, "Disclosing Mental Illness Among Korean Americans Is Losing Face," KoreanAmericanStory.org, January 31, 2013, https://koreanamericanstory.org/written/disclosing-mental-illness-among-korean-americans-is-losing-face/.

[43] Mao-Sheng Ran et al., "Stigma of Mental Illness and Cultural Factors in Pacific Rim Region: A Systematic Review," *BMC Psychiatry* 21, no. 8 (2021): 10, https://doi.org/10.1186/s12888-020-02991-5.

[44] Ran et al., "Stigma of Mental Illness and Cultural Factors in Pacific Rim Region"; "Kuei-Hsiang Han, "The Feeling of 'Face' in Confucian Society: From a Perspective of Psychosocial Equilibrium," *Frontiers in Psychology* 7 (July 19, 2016), https://doi.org/10.3389/fpsyg.2016.01055.

[45] Zuk-Nae Lee, "Korean Culture and Sense of Shame," *Transcultural Psychiatry* 36, no.2 (1999): 188–92, https://doi.org/10.1177/136346159903600202.

[46] Yang and Rosenblatt, "Shame in Korean Families," 373.

and endure by themselves, rather than to disclose their "weakness."[47] The outcomes of the above research provide ground for further examination of how public and religious sanist views/stigmas against schizophrenia are interpreted, accepted, and become intertwined with the impacts of cultural understandings of shame coupled with the cultural and collective pressure to save face, in the Korean church context.

Pastoral Theology, Care and Counseling Literature

Although there is relatively little research into the topic of schizophrenia from pastoral care and counseling literature, some outstanding scholarly works have been published specifically on schizophrenia and other severe mental illnesses—including a few monographs by Stewart D. Govig (1994, 1998), John Swinton (2000, 2020), Kathleen J. Greider (2007), Donald E. Capps (2010), Rosemary R. Ruether (2010) and Elahe Hessamfar (2014), a chapter by Joretta L. Marshall (2019), and journal articles by Marion L. S. Carson (2006) and Jason Whitehead (2016).

However, after reviewing the literature, I discovered the need for further research to implement expanded concepts of spiritual care and counseling for schizophrenia, particularly within the congregational setting. Many theological writings focus on medical and psychosocial education around schizophrenia, which is essential for the provision of an appropriate and adequate basic level of care for the affected population and their families in the North American Protestant church context. Some theological research has been carried out to build alternative, deepened theological reflection on themes such as the incomprehensibility of suffering from mental illness or God's role in human suffering. New theological ideas defy traditional Christian theologies that do more harm than good for affected people because of their negative inference to

[47] Jee Eun Park et al., "Impact of Stigma on Use of Mental Health Services by Elderly Koreans," *Social psychiatry and psychiatric epidemiology* 50, no. 5 (2015): 757-66, doi:10.1007/s00127-014-0991-0.

divine punishment. However, the new theological constructs still uphold the predominant medical and psychiatric explanation of mental illness, which diminishes the possibility of non-pathologically conceptualizing the meanings of suffering.

It is worth noting that some meaningful investigations have been carried out in regard to the theological and spiritual aspects of living with the social suffering of schizophrenia. This includes studies carried out by pastoral theologians Kathleen Greider, John Swinton, Elahe Hessamfar, Stephen Pattison, Joretta Marshall, and Jason C. Whitehead. By shedding light on the religious or spiritual dimension of the tangled reality of living with mental illness, these authors warn against reducing people's identity and life to their diagnosis and the psychiatric description of their symptoms. They suggest exploring the unique spiritual dimension of living with schizophrenia. While their exhortations are designed to help prevent the psychiatrization of people's identities and lives, they have not fully addressed the discriminatory views embedded in the pathological and psychiatric explanations of people's lived experiences with schizophrenia. In other words, within existing pastoral theological literature, the psychiatric paradigm still remains unchallenged, being considered one of the best ways to depict the reality of people's lived experiences of mental illness. I interpret this tendency as being a result of historical chronology, as the new movements and disciplines that proactively rely on the knowledge of people with lived experience had not fully emerged during the time of their writing.

Nevertheless, two significant scholars offer insights to delve deeper into researching the topic from alternative perspectives, in order to avoid adopting the view of dominant psychiatric discourse: John Swinton and Elahe Hessamfar. Swinton has authored two monumental books, *Resurrecting the Person* and *Finding Jesus in the Storm*, centered on schizophrenia or psychosis, which highlight various dimensions of people's lived experiences and provide detailed

theological reflections on their experiences. Highlighting the issues and consequences of medicalization, Swinton's *Resurrecting the Person* provides detailed plans that the church can employ to be systematically and theologically prepared to care for the population within the congregational setting.[48]

In her book *In the Fellowship of His Suffering*, Elahe Hessamfar provides meaningful insight into challenging the authoritative disciplines of psychopathology and psychiatry. Critically reviewing the history of psychiatry and raising questions about its scientific validity in "alleviating human emotional distress,"[49] Hessamfar suggests regarding mental distress "as an expression of human variation and not pathology" and turning to "a theological lens" to address pastoral theological issues around it.[50]

However, in her meaningful theological approach to schizophrenia, her research nuances the negative aspects of schizophrenia as an excruciating illness, although she intends to positively and creatively reconstruct its theological meanings as more than mere suffering or tragedy. This is similar to an article written by pastoral theologian Ryan LaMothe. He takes a different look at the human phenomenon of madness and ponders its implication for pastoral theological methods. LaMothe clarifies at the beginning of his writing that "the very real suffering of persons with schizophrenia, psychosis, etc.," is not included in his consideration of the pastoral methodological use of madness.[51] The works of Hessamfar and LaMothe, while significantly valuable, limit themselves by not fully including the entire extents of the lived experiences of people with mental illness in their reconstruction. This leads them to exclude the

[48] Swinton, *Resurrecting the Person*, 145-91.
[49] Hessamfar, *In the Fellowship of His Suffering*, 139.
[50] Hessamfar, *In the Fellowship of His Suffering*, 143.
[51] Ryan LaMothe, "Madness and Method: A Pastoral Theological Reflection," *Pastoral Psychology* 65, no. 6 (December 2016): 787-88, https://doi.org/10.1007/s11089-016-0709-1.

consideration of a radical, mad-affirming approach to undiscovered dimensions and meanings of suffering. Therefore, given the need for more research through a perspective other than psychiatry, my dissertation aims to utilize the values of the non-pathologizing and mad-affirming approach towards schizophrenia to explore creatively the spiritual meanings within the experience of it.

The possibility of such academic research has been suggested in Swinton's recent work, *Finding Jesus in the Storm: The Spiritual Lives of Christians with Mental Health Challenges*. Until the book came out, theological works focusing on listening to the experiential knowledge of people with schizophrenia had not been published. Swinton's *Finding Jesus in the Storm* has been in line with the shift to the non-pathological theological perspective by offering the promise of reconstructing a theology that validates and creatively explores depathologizing the lived experiences of mental health issues, particularly, depression, psychosis, and mania.

Arguing about the need to change the pathologizing language in the Diagnostic Statistical Manual (DSM) to an unconventional, positive, and compassionate language, Swinton approaches the experience of mental illness with the goals to capture "the phenomenological dimension" of people's complex life realities, discover their "lived theology," and revise both theology and practice around mental illness.[52] Swinton's alternative theological approach, which acknowledges but aims to transcend the dominant medical model of mental illness, serves as an example of how theology's dialogue with people's experiential knowledge of various mental distresses can unveil the multifaceted dimensions of their lives. This provides an opportunity for holistic healing without excluding or overly focusing on any specific dimension of mental

[52] John Swinton, Introduction to *Finding Jesus in the Storm: The Spiritual Lives of Christians with Mental Health Challenges* (Grand Rapids, Michigan: William. B. Eerdmans Publishing Company, 2020). ProQuest Ebook Central, http://ebookcentral.proquest.com/lib/dtl/detail.action?docID=6407720.

illness. Drawing from his phenomenological approach to the lived experiences of mental illness, Swinton concludes by explaining how healing takes place in seven dimensions of people's lives: Cultural, Liturgical, Biblical, Theological, Epistemic, Testimonial, and Relational.[53] Swinton's research contributes to my reflection on the outcomes spiritual care should deliver for people with schizophrenia in the Korean church.

Schizophrenia and the Church

The church community has been regarded as one of the communities that has relational and spiritual resources to support people with schizophrenia and their families. However, the Christian theology of mental illness commonly held in the North American Protestant church has often operated in ways that simply reproduce and strengthen religious stigma that prevents the affected population from seeking help from the church.[54] An individual's and the church's theology of mental illness is formed and developed usually upon one of two models, spiritual-moral and bio-medical. The spiritual interpretations of mental illness in relevant stories from the Christian scriptures—for instance, the Gerasene Demoniac narrative (Mk 5:1-17; Lk 8:26-37)—create a negative religious stigma against mental illness that perpetuates negative stereotypes, a harsh attitude, and discrimination towards those living with mental illness.[55]

The purely biomedical view of schizophrenia immobilizes theological or spiritual domains. Limiting the scope of their experiences to medicalization and pathologization engenders the irrelevancy and uselessness of theology to people's lives in the creation of meanings.[56] Whether inevitable or not, biologicalisation/psychiatrization of human experiences labeled as schizophrenia impedes the exploration of a theological or spiritual dimension in those

[53] Swinton, *Finding Jesus in the Storm*.
[54] Albers, "Introduction, First Edition," xiii; Scrutton, *Christianity and Depression*, 37.
[55] Simpson, *Troubled Minds*, 155-65, Kindle; Scrutton, *Christianity and Depression*, 31-36.
[56] Hessamfar, *In the Fellowship of His Suffering*, 30-31.

lives, including both their suffering and non-suffering affairs. The bio-psychiatric paradigm of schizophrenia cannot successfully resolve the issues of stigma and shame either because of its basic assumptions about mental illness and its implications: People who have relevant experiences are not considered to be rational, normal, or able, thus deemed lesser full human beings.[57] In the case of severe mental illness such as schizophrenia, the psychiatric diagnosis imposes on the sufferer negative and restrictive stereotypes such as dangerousness, lack of credibility and communicability, and irrationality—which are regarded as traits of human inferiority. This inevitably results in the isolation/alienation of people with mental illness under the impacts of the internalized sanist view of themselves.[58]

Regardless of the impact of various types of stigma in the church, we have theological and spiritual resources for those with these lived experiences and their families that might help them to flourish in their lives. Research has confirmed that people experiencing schizophrenia have expressed high interest in exploring the spiritual meaning of life, including their lived experiences of schizophrenia.[59] Without romanticizing or fantasizing about suffering and the burdens that accompany schizophrenia, and without absolutizing psychiatric explanations in the theological construction of suffering, a spiritual or theological exploration of schizophrenia that is more open to affirming people's Mad experiences helps reconstruct an inclusive, liberating, and empowering understanding of living with schizophrenia based on their experiential knowledge.

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[57] Robert Menzies, Brenda A. LeFrançois, and Geoffrey Reaume, "Introducing Mad Studies," in *Mad Matters: A Critical Reader in Canadian Mad Studies*, ed. Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume (Toronto: Canadian Scholars' Press, 2013), 10.

[58] Ji-Eun Lee, "Mad as Hell: The Objectifying Experience of Symbolic Violence," in *Mad Matters: A Critical Reader in Canadian Mad Studies*, ed. Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume (Toronto: Canadian Scholars' Press, 2013), 115-16.

[59] Daniel B. Morehead, "Hearing Voices: Pastoral Care for People with Schizophrenia," in *The Church Leader's Counseling Resource Book: A Guide to Mental Health and Social Problems*, ed. Cynthia Franklin and Rowena Fong (Oxford; New York: Oxford University Press, 2011), 206.

Mad Studies and Critical Mental Health

Psychiatrization of Society

Despite the good intentions behind medicalizing mental illnesses, including schizophrenia, the domination of psychiatric discourse over people's mental distress has led to a scarcity of other perspectives. In recent years, psychiatry has gained significant popularity in Korea, with psychiatrists receiving substantial media attention, an increasing number of people seeking general life advice from psychiatrists, and psychiatrists becoming sought after more often than other medical professionals.[60] This phenomenon can be referred to as the "psychiatrization" of Korean society, in which psychiatrization is defined as

> a complex process of interaction between individuals, society, and psychiatry through which psychiatric institutions, knowledge, and practices affect an increasing number of people, shape more and more areas of life, and further psychiatry's importance in society as a whole.[61]

The psychiatrization of society has been observed as a prevailing trend both in Western societies and in Korea, one of the most Westernized Asian countries. While the phenomenon of psychiatrization has both positive and negative aspects, it is concerning that psychiatry's perspective is predominantly seen as the sole credible and most authoritative voice in understanding and describing the lives of individuals—both those experiencing mental distress but also those who are not.[62] In opposition to this trend, grassroots movements and disciplines

[60] Geun-ho Im, "Bulan, seuteureseu ... Seojom-ganeun jigeum 'jeongsingwa uisa jeonseongsidae'" [Anxiety, stress: The "heyday of the psychiatrist" in the book market], *Hanguk Gyeongje*, January 18, 2023; Jeong-Jin Kim, "Talgwonwi, chiyu, wiro ... 'Gungmin mento'ro yeongyeok neolbhi-neun O Eun-yeong baksa" [Non-authoritarian, healing, and comfort: Dr. Eun-Young Oh expanding her influence as a "national mentor"], *Yeonghap News*, November 29, 2021; An-gi Hong, "'Pianseong' ingi neom-eun jeongsingwa ... Sunbae jeonmun-uiga bon bigyeol?" [Psychiatry is more popular among medical students than dermatology, ophthalmology, plastic surgery: How does a senior specialist view this?], *Uihyeob Sinmun*, December 12, 2023.

[61] Timo Beeker et al., "Psychiatrization of Society: A Conceptual Framework and Call for Transdisciplinary Research," *Frontiers in Psychiatry* 12 (June 4, 2021): 3, https://doi.org/10.3389/fpsyt.2021.645556.

[62] Beeker et al., "Psychiatrization of Society," 7.

have emerged to challenge the dominance of psychiatric language and the essentialization and pathologization of experiences of mental distress.

New Movements

As psychiatry gains more influence, certain groups of people undergoing psychiatric treatment and their allies are raising questions and offering critiques of the dominant medical and psychiatric discourse, as well as the practices and treatments it justifies. Under the state's authority, psychiatry wields unquestionable power in determining and explaining people's lived experiences of "mental illness."[63] Michel Foucault stresses that the combination of these authoritative psychiatric standards and societal norms within a specific community establishes social guidelines that compel people to conform to the roles and expectations around what is considered normal and sane.[64] Consequently, more individuals with lived experiences of mental illness are becoming dissatisfied and angered by this erosion of their humanity and right to meaning and decision-making.

One such movement is Mad Studies—a newly emerging discipline that originated from Canada and is indebted to anti- and critical-psychiatry and psychiatric survivor and user movements, and other precedent movements such as feminism and queer studies. It "aims to celebrate community and positive aspects of altered states of mind, without pathologising those experiences or glamorising or effacing what may be experienced as deep and unbearable distress."[65] That is to say, Mad Studies recognizes mental illness as one of the social categories

[63] Stephen Pattison, *Pastoral Care and Liberation Theology*, Cambridge Studies in Ideology and Religion (Cambridge; New York: Cambridge University Press, 1994), 88-95.

[64] Neree St-Amand and Eugene LeBlanc, "Women in 19th-Century Asylums: Three Exemplary Women; A New Brunswick Hero," in *Mad Matters: A Critical Reader in Canadian Mad Studies*, ed. Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume (Toronto: Canadian Scholars' Press, 2013), 39; Simone Fullagar, "Foucauldian Theory," in *Routledge International Handbook of Critical Mental Health*, ed. Bruce M. Z. Cohen (London: Routledge, 2018), 41.

[65] Rachel Gorman and Brenda A. LeFrançois, "Mad Studies," in *Routledge International Handbook of Critical Mental Health*, ed. Bruce M. Z. Cohen (London: Routledge, 2018), 108.

"like race, class, gender, sexuality, age, or ability that define [mad people's] identities and experiences."[66] Mad Studies scholars point out that the term is an umbrella under which can be included various approaches to understanding madness as a human experience. Another discipline that falls under this umbrella is antipsychiatry, which completely denies the existence of mental illness and aims to abolish psychiatry.[67] I acknowledge psychiatric and pharmaceutical treatments are valuable—and even necessary, to a certain degree, but I am also interested in the non-pathological, mad-affirming, and humane approach that values and uses the experiential knowledge of the psychiatrized people in the course of determining treatment and addressing issues of violence, oppression, and exploitation by the psychiatric system and pharmaceutical industry.

Mad Studies employs the notion of madness "as a means of self-identifying, and as a point of entry into the fields of power where their encounters with organized psychiatry, and their very lives, play out."[68] By reexamining and validating of the subjectivity of the psychiatrized people, Mad Studies critically reflects on and replaces the dominant—and often inhuman—psychiatric discourse with "the language of madness" that offers better explanation and representation of them, and thus is in position to improve and advocate for their wellbeing.[69] Unlike other theoretical or ideological approaches to mental illness, the emphasis of this discipline is on the radical change in social status and treatment and in the lives of psychiatrized

[66] Maria Liegghio, "A Denial of Being: Psychiatrization as Epistemic Violence," in *Mad Matters: A Critical Reader in Canadian Mad Studies*, ed. Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume (Toronto: Canadian Scholars' Press, 2013), 122.

[67] Shaindl Diamond, "What Makes Us a Community?: Reflections on Building Solidarity in Anti-sanist Praxis," in *Mad Matters: A Critical Reader in Canadian Mad Studies,* ed. Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume (Toronto: Canadian Scholars' Press, 2013), 66-7.

[68] Menzies, LeFrançois, and Reaume, "Introducing Mad Studies," 9.

[69] Menzies, LeFrançois, and Reaume, "Introducing Mad Studies," 10.

people. Mad Studies scholars believe that validating the experiential knowledge of those with lived experiences of mental illness is the key to change and transformation.

Another newly emerging discipline, Survivor Research—influenced by emancipatory voices and survivor movements in the UK—also recognizes the potential of radical change through the "accounts, views and explanations" of service users/survivors. This is possible only by critically interrogating "the conventional, medicalised, individual focus of much mainstream [mental health] research" that places "emphasis on diagnostic categories and 'treatment' responses.'"[70] Because it is innately at odds with psychiatry, Mad Studies has emerged as an "in/discipline" that dismantles the existing epistemological view on humans and human experiences held by other disciplines within established academia.[71]

Sanism

One of the issues underlying psychiatrized people's oppression and marginalization is sanism.[72] Michael L. Perlin, a legal scholar who popularized the term, defines sanism "as an irrational prejudice against people with mental illness, is of the same quality and character as other irrational prejudices such as racism, sexism, homophobia, and ethnic bigotry that cause (and are reflected in) prevailing social attitudes."[73] Perlin adds that those prejudices imply:

> that people with mental illness are erratic, deviant, sexually uncontrollable, emotionally unstable, superstitious, lazy, and ignorant; that they demonstrate a primitive morality; they are invariably more dangerous than persons without mental illness, and such

[70] Peter Beresford and Diana Rose, "Background," in *This Is Survivor Research*, ed. Angela Sweeney et al. (Ross-on-Wye: PCCS Books, 2009), 18.

[71] Richard Ingram, "Doing Mad Studies: Making (Non)sense Together," *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice* 5, no.3 (2016): 12-13.

[72] The term sanism is intentionally employed rather than the term stigma in my research to cover the range that stigma covers—stereotypes, prejudices, and discrimination on many levels—but also expand the meaning to include injustice, oppression, and dehumanization of the current psychiatric system and pharmacological industry in their essentializing as invariable certain features of schizophrenia and absolutizing psychiatric explanations of people's lived experiences as the essence of their life, and forcing all forms of involuntary treatments.

[73] Michael L. Perlin, "International Human Rights and Comparative Mental Disability Law: The Role of Institutional Psychiatry in the Suppression of Political Dissent," *Israel Law Review* 39, no. 3 (2006): 74. https://doi.org/10.1017/S0021223700013145.

> dangerousness is easily and accurately identified by experts; that for a person in treatment for mental illness to decline to take prescribed antipsychotic medication is an excellent predictor of (1) future dangerousness and (2) need for involuntary institutionalization; that people with mental illness should be segregated in large, distant institutions because their presence threatens the economic and social stability of residential communities; that they give in too easily to their basest instincts and do not exercise appropriate self-restraint.[74]

Expanding on Perlin's definition, Mad Studies scholars' definition of sanism accounts for psychiatric oppression and violence carried out against people diagnosed with mental illness as well.[75] While the term stigma is more widely used in academic disciplines and in society overall, Mad Studies scholars and activists argue that the term falls short of fully disclosing the prevalent and insidious oppression and abuse those with experiences of mental illness face because the term is actively co-opted and commercialized by psychological industry and the psychiatric system.[76] Unless sanism is thoroughly dealt with, there is no way to change the status quo of sanist and ableist prejudices towards people with lived experiences of madness.[77]

There are two sanist assumptions imposed more strongly on schizophrenia than on other mental illnesses because expressions of schizophrenia include hallucinations or delusions as symptoms of psychosis.[78] This causes people to believe that individuals with schizophrenia are extremely dangerous, have no insight into their illness ("anosognosia"), and no ability to make decisions for their treatment or lives in general. These degrading, discriminatory assumptions are used as rationale to force people into involuntary treatment and hospitalization and inevitably

[74] Michael L. Perlin, "Sanism and the law," *Virtual Mentor* 15, no.10 (2013):878, https://doi.org/10.1001/virtualmentor.2013.15.10.msoc1-1310.

[75] Gorman and LeFrançois, "Mad Studies," 110.

[76] Gorman and LeFrançois, "Mad Studies," 110.

[77] Poole et al., "Sanism, 'Mental Health', and Social Work/Education," 29.

[78] Catherine van Zelst, "Stigmatization as an environmental risk in schizophrenia: a user perspective," *Schizophrenia bulletin* 35, no.2 (2009): 293-6. https://doi.org/10.1093/schbul/sbn184.

into segregation.[79] Opposing those discrediting views the psychiatric survivors/researchers/allies in the Mad Studies group aim to reclaim their subjectivity by explaining their experiences in their own words. User-led research scholar Peter Beresford makes it clear in his explanation of the emergence of Mad Studies that "we [mad people] do not have to be framed in terms of individual pathology and transcending this is better for everyone."[80]

Sanist assumptions need to be reevaluated and reframed to justly represent diversity in life and acknowledge membership of those with lived experiences of schizophrenia in society. Validating people's subjectivity and right to make decisions is closely related to justice issues on an epistemic level. Maria Liegghio, who conducts research on the stories of psychiatric survivors, declares the deprivation of mad people's subjectivity, the discreditation of their capacities to think and act for themselves, and the enforcement of psychiatric regulations, epistemic injustice and violence.[81] Such epistemic injustice and violence refers to individuals with schizophrenia as "flawed or disordered in the way of seeing, perceiving, judging, and thus, knowing reality"[82] and devalues ultimately denies their existence in society. Liegghio asserts that we need to grant them "legitimacy" and the status of "legitimate knowers" of their personhood and lived experiences.[83]

To overcome the unjust recognition and treatment of mad people, some Mad scholars attempt to reevaluate and celebrate mad experiences as the expressions of an individual's "neurodiversity" by challenging the social norms of what is considered deviant, abnormal, inferior, or even dangerous. By doing so, they hope to create a society more accepting of

[79] Nicolas Badre, Shawn S. Barnes, David Lehman, and Sandra Steingard, "Coercion and the Critical Psychiatrist," in *Critical Psychiatry: Controversies and Clinical Implications*, ed. Sandra Steingard (New York: Springer, 2018), 168.

[80] Beresford, "'Mad', Mad Studies and Advancing Inclusive Resistance," 1341.

[81] Liegghio, "A Denial of Being," 122-29.

[82] Liegghio, "A Denial of Being," 126.

[83] Liegghio, "A Denial of Being," 126-27.

people's diversity, and one that acknowledges people's right to "self-definition" and "self-determination."[84]

The idea that people with schizophrenia are too dangerous to live freely in society also needs to be reevaluated. The fact of the matter is that the chances of a person with schizophrenia becoming a perpetrator of violence are exaggerated, while their chances of becoming a victim are vastly underestimated.[85] In addition, Mad Scholars argue that the notion of being a danger to themselves (such as being suicidal) and others needs to be reconsidered because violence cannot be attributed entirely to factors related to psychiatric illness.[86] Mad Scholars point out that harm and violence in people's lived experiences of madness are in many cases related to the people's traumatic past experiences, including forced treatment and hospitalization, and the emotions that result from this.[87] Alternative efforts around acts of violence by those lived experiences of madness respond to them "in the most humane, compassionate way possible that considers the contextual and systemic circumstances surrounding the threat or act of violence that has occurred."[88] Importantly, these approaches do not minimize or ignore the risks or potential harm that extreme mental/emotional distress can cause to oneself or others.

There have been alternative attempts to reflect on a more experience-affirmative, non-pathologizing approach to people's experiences with psychosis. For example, in explaining the Hearing Voices Movement, psychologist Lucy Johnstone argues that it is an "emancipatory

[84] Steve Graby, "Neurodiversity: Bridging the Gap between the Disabled People's Movement and the Mental Health System Survivors' Movement?," in *Madness, Distress and the Politics of Disablement*, ed. Helen Spandler, Jill Anderson, and Bob Sapey (Bristol: Policy Press, 2015), 234-38; Emily Sheera Cutler, "Listening to Those with Lived Experience," in *Critical Psychiatry: Controversies and Clinical Implications*, ed. Sandra Steingard (New York: Springer, 2018), 189-190.

[85] Torrey, *Surviving Schizophrenia*, 252-54; 361-363.

[86] Cutler, "Listening to Those with Lived Experience," 194-195.

[87] Webb, "Thinking (differently) about suicide," 94-95; Cutler, "Listening to Those with Lived Experience," 197-200.

[88] Cutler, "Listening to Those with Lived Experience," 200-01.

approach" rather than a "treatment approach," aiming to alter the societal perception of voice hearers and, by extension, other individuals labeled as "psychiatrically ill."[89] Johnstone contends that the alternative approach implies viewing voice hearers as "*people with problems*" rather than "*patients with illnesses*."[90]

Johnstone further suggests that this new approach seeks to validate the meanings and values inherent in people's lived experiences of voice hearing, avoiding pathologizing and abnormalizing, thereby preventing the experiencer from becoming powerless, passive victims.[91] Emphasizing the importance of respecting individuals' decisions, Johnstone argues for a shift in the role of professionals to assist people in choosing their own path of recovery, one that empowers and sustains their lives while reducing the adverse effects of hearing voices.[92] The premise of Johnstone's argument is rooted in the belief that the psychiatric diagnosis and treatment approach hinder the possibility of meaningful decision-making from the outset.[93] This is well demonstrated in her proposal of a formulation model to approach people's experiences, rather than merely labeling them with and viewing them through diagnoses.[94]

Another example is provided by clinical psychologist Rufus May, who conducts his clinical work for people with psychosis based on this philosophical foundation: "*Unusual beliefs are meaningful and symbolic, they are not merely the bizarre misfirings of a faulty brain.*"[95]

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[89] Lucy Johnstone, "Voice Hearers are People with Problems, Not Patients with Illnesses," in *Psychosis as a Personal Crisis: An Experience-Based Approach*, The International Society for the Psychological Treatments of Schizophrenias and Other Psychoses Book Series, ed. M. A. J. Romme and Sandra Escher (London New York: Routledge, 2012), 28-29.

[90] Johnstone, "Voice hearers are people," 29. Italics in the original.

[91] Johnstone, "Voice hearers are people," 29.

[92] Johnstone, "Voice hearers are people," 29-30.

[93] Johnstone, "Voice hearers are people," 30.

[94] Johnstone, "Voice hearers are people," 30-35.

[95] Rufus May, "Relating to Alternative Realities," in *Psychosis as a Personal Crisis: An Experience-Based Approach*, The International Society for the Psychological Treatments of Schizophrenias and Other Psychoses Book Series, ed. M. A. J. Romme and Sandra Escher (London New York: Routledge, 2012), 141. Italics in the original.

Reviewing his own experiences of unusual beliefs through their formative history, motives, and emotions, May focuses on the significance of meanings and internal logic embedded in people's delusions and how they serve better the individual's interests of recovery when approached with sympathetic and validating listening.[96] The issue rather lies in the lack of social acceptance and support for those with unusual beliefs and May addresses this problem by offering practical guidelines to flexibly and effectively attend to people's lived experiences, thereby fostering the best outcomes for them.[97]

While the issues of epistemic injustice are central to the sanism against people with schizophrenia, other injustices for the group also need to be addressed. In her authored chapter in *Injustice and the Care of Souls: Taking Oppression Seriously in Pastoral Care*, disability theologian Carolyn R. Thompson draws on the political theorist Iris Marion Young's "Five Faces of Oppression" as multidimensional systemic, structural oppression and expands the notion to insightfully capture the realities of oppressions people with disabilities undergo in daily life.[98] Listing the five manifestations of sociocultural oppression, "cultural imperialism, marginalization, powerlessness, exploitation, and violence,"[99] Thompson asserts, "Structural oppression resides in, and is propagated by, unquestioned beliefs, language, and laws that govern our institutions and the subsequent blind adherence to unjust rules they impose."[100]

Thompson's keen recognition of the realities of oppression greatly aligns with that of sanism more tailored to the psychiatrized people. Her detailed examples of different levels of oppression, listed with the ordinary experiences of the group of people with disabilities, shed

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[96] May, "Relating to Alternative Realities," 141-43.
[97] May, "Relating to Alternative Realities," 142-52.
[98] Carolyn R. Thompson, "Ableism: The Face of Oppression as Experienced by People with Disabilities," in *Injustice and the Care of Souls: Taking Oppression Seriously in Pastoral Care*, ed. Sheryl A. Kujawa-Holbrook and Karen B. Montagno, 2nd ed. (Minneapolis: Fortress Press, 2023), 234-35.
[99] Thompson, "Ableism," 236.
[100] Thompson, "Ableism," 235.

light on various levels of injustices and oppressions imposed both bluntly and subtly on those associated with schizophrenia. Thompson's work will be drawn again upon in Chapter 6, where Korean pastors' narratives of spiritual care for people with schizophrenia will be examined through the concept of sanism, to unveil injustices prevailing underneath their experiences.

Spirituality

The purely biomedical view of schizophrenia limits theological or spiritual domains. Confining these experiences to medicalization and psychiatrization renders theology irrelevant and useless in the creation of meaning in people's lives.[101] Regardless of the impact of various types of stigma in the church, theology and spirituality offer resources for individuals with these lived experiences and their families, enabling them to flourish in their lives. Research confirms that people experiencing schizophrenia express a strong interest in exploring the spiritual meaning of life, including their experiences of schizophrenia.[102] Without romanticizing or idealizing suffering and the burdens that accompany schizophrenia, and without absolutizing psychiatric explanations in the theological construction of suffering, spiritual and theological exploration of schizophrenia helps reconstruct an inclusive, liberating, and empowering understanding of living with schizophrenia based on the experiential knowledge of those who have lived through it. Three key areas at the intersection of religion/spirituality and schizophrenia that are worth exploring are: 1) Religious/spiritual experiences of the person with schizophrenia and their meanings, 2) Religious/spiritual resources and practices related to living with schizophrenia, and 3) Religious/spiritual dimension and meanings of individuals' lived experience with schizophrenia. Compared to the second and third categories, the group's direct

[101] Lauren J. Tenney, "Spirituality, Psychiatry, and Mad Studies," in *The Routledge International Handbook of Mad Studies*, ed. Peter Beresford and Jasna Russo (London: Routledge, 2022), 291.

[102] Philippe Huguelet et al., "Spirituality and Religious Practices Among Outpatients with Schizophrenia and Their Clinicians," *Psychiatric Services* 57, no. 3 (March 2006): 368-71, doi:10.1176/appi.ps.57.3.366.

religious or spiritual experiences are more frequently considered and disregarded as pathological, with concerns about potentially confusing or worsening the individuals' conditions.[103] Writings from the alternative mental health and mad-affirming movements, such as the Hearing Voices Movement, contend that religions and spirituality play crucial roles in people's healing and liberation. These roles are unbounded and not co-opted by psychiatric and psychological discourse.[104]

Feminist Studies of Care

Caregiving has been a popular research subject for Feminist Studies, given the history of women who have been culturally assigned care tasks at home or within a professional setting. Despite its tremendous vitality in sustaining people's lives, formal and informal care as a human act—mainly when conducted by women—has often been overlooked, neglected, underappreciated, and unfairly under-compensated throughout history. And not only that, but the burden of care has also disproportionately centered on women.[105] Due to this injustice pervading the care parameter, it has had a paradoxical nature. That is, while care has functioned to assist in meeting the basic and advanced life needs of those relying on others' care, people on both ends—care receivers and caregivers—inevitably undergo harm, damage, exploitation, and even dehumanization. Care receivers vastly rely on care at various levels from the caring acts of others, but simultaneously, they frequently experience unfair treatment, abuse, marginalization,

[103] James L. Griffith, *Religion That Heals, Religion That Harms: A Guide for Clinical Practice* (New York: Guilford Press, 2010), 206-23.

[104] For examples, Claire Bien, *Hearing Voices, Living Fully: Living with the Voices in My Head* (London: Jessica Kingsley Publishers, 2016); John Gale, ed., *Insanity and Divinity: Studies in Psychosis and Spirituality*, Book Series of the International Society for Psychological and Social Approaches to Psychosis (London: Routledge, 2014); Stanislav Grof and Christina Grof, eds., *Spiritual Emergency: When Personal Transformation Becomes a Crisis*, New Consciousness Reader (Los Angeles: Tarcher, 1989).

[105] Eva Feder Kittay, "When Caring is Just and Justice is Caring: Justice and Mental Retardation," in *The Subject of Care: Feminist Perspectives on Dependency*, ed. Eva Feder Kittay and Ellen K. Feder, Feminist Constructions (Lanham, Md: Rowman & Littlefield Publishers, 2002), 260-61.

and objectification.[106] On the other hand, although caregivers hold a more powerful position in an asymmetric relation with those for whom they are charged to care, they frequently become a victim of abuse, overwork, exploitation, and the discreditation of their contribution to the wellness of individuals cared for and society.[107] These issues of care have been exacerbated and deepened by disparities embedded in race/ethnicity, gender, class, and religion.[108]

Feminist studies lend a lens to identifying and critically investigating these malfunctioning and damaging issues to those involved in care, tackling them by questioning the current contexts of both parties in care interaction, which are often regarded as unchangeable and unimprovable. Feminist studies carry three implications for the discussion of spiritual care of people with schizophrenia. First, feminist scholars reexamine the roles and positions of those who benefit from caregiving, especially those whose conditions requiring care are innate and permanent. These research investigations offer rich insight that allows us to redefine human capacities in terms of their effects on others and relationships. Second, the focus of mutuality in caring relationships is placed by feminist studies researchers to redress the imbalance in a caring relationship.[109] Lastly, feminist scholars pay attention to justice issues in caregiving, especially for caregivers, in an effort to change the unfair distribution of duties, power imbalances, and under-appreciated values in a traditional caring relationship. New views on care receivers and caring relationships show the promise of caregivers receiving some benefit from their participation in the situation beyond the traditional forms of compensation.

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[106] Kittay, *Learning from My Daughter*, 177-8.

[107] Sandra Sullivan-Dunbar, *Human Dependency and Christian Ethics*, New Studies in Christian Ethics (Cambridge, United Kingdom: Cambridge University Press, 2017), 18.

[108] Sullivan-Dunbar, *Human Dependency and Christian* Ethics, 10-21, 27; Sandra Sullivan-Dunbar, "Christian Love, Material Needs, and Dependent Care: A Feminist Critique of the Debate on Agape and 'Special Relations,'" *Journal of the Society of Christian Ethics* 29, no.2 (December 2009).

[109] Mutuality is also considered one of the essential tenets of feminist pastoral leadership, authority, ecclesiology, and theology of God; Graham, "Feminist Critiques, Visions, and Models of the Church," in *The Oxford handbook of ecclesiology*, ed. Paul Avis (Oxford: Oxford University Press, 2018), 538-39.

The first contribution of feminist studies to the discussion of care is its attempt to reappraise human values and capabilities. Feminist scholars discuss the longstanding history of mainstream philosophical studies that assert that the wholeness of a human being is fundamentally grounded on the function of reason as a cognitive capacity.[110] The epistemic injustice, manifested in devaluing other human capabilities in favor of normativity constructed upon the belief of rationality, results in assigning a lower social status to individuals who are persons of color, uneducated, non-male-cis-gendered, or with disabilities, treating them as lesser human beings.[111] The feminist studies of care inspire a reevaluation of human abilities by considering those with conditions that impede their normal functioning and their ability to exist independently as whole persons, challenging the definitions set by European and North American societies.[112]

Feminist studies began in resistance to unfair treatment of women, which has led to the interrogation of the assumptions about and roles and expectations of women in society, which had previously been developed by those with "power/privilege," not by those with lived knowledge about being and living as women.[113] This feminist epistemology as liberatory epistemology equips people to recognize "knowledge obscured by dominant interests and values" and undermine oppressive knowledge and practice.[114] This goal includes "reclaiming dimensions of human capacities that had been excluded from the domains of reason and rationality."[115] That means feminist epistemology facilitates the discovery of traditionally

[110] Kittay, "When Caring is Just and Justice is Caring," 262-63.

[111] For examples, refer to PART 2 of Ian James Kidd, ed., *The Routledge Handbook of Epistemic Injustice* (London: Routledge, 2017).

[112] Jenny Morris, "Impairment and Disability: Constructing an Ethics of Care That Promotes Human Rights," *Hypatia* 16, no. 4 (2001): 10.

[113] Nancy Tuana, "Feminist Epistemology" in *The Routledge Handbook of Epistemic Injustice*, ed. Ian James Kidd, José Medina, and Gaile Pohlhaus (London; New York: Routledge, 2017),125.

[114] Tuana, "Feminist Epistemology," 125.

[115] Tuana, "Feminist Epistemology," 127.

unappreciated and eclipsed human capacities within those regarded as lesser human beings because their expressions and behaviors were deemed unreasonable and insignificant.

Drawing on her experience as a familial caregiver to her daughter with an intellectual disability, feminist philosopher Eva F. Kittay encourages a reconsideration of care receivers' ability to reciprocate and contribute to the caring of their caregivers. This suggestion extends beyond the traditional understanding of human dependency. Kittay questions the validity of the assumption that the capacity to cooperate with others, based on rationality and reason, should be centered on the prerequisite of being a "free" and "equal" moral agent in terms of justice.[116] Kittay argues that the argument of John Rawls, who aligns with the Humean tradition valuing human reason and rationality as "moral powers," inevitably excludes the populations such as people with intellectual disabilities who lack and do not meet the criteria of "fully functioning" moral beings.[117] Despite the potential risk entailed in her approach to unintentionally "romanticize the rewards of caregiving,"[118] Kittay's works shed light on the other ways of reciprocity performed by a care receiver as an active agent within meaningful human relationships: From which a caregiver experiences "deep fulfillment," and special joys from the dependent's "loving gaze and laughter,"[119] being aware of "what is important and precious," and emotional and relational interdependence,[120] despite the impairments or burdens their intellectual disabilities create.

Pamela Cushing and Tanya Lewis, who researched caring relations between caregivers and people with severe intellectual disabilities at L'Arche homes, provide another case of under-

[116] Kittay, "When Caring is Just and Justice is Caring," 262-63.
[117] Kittay, "When Caring is Just and Justice is Caring," 263.
[118] Sandra Sullivan-Dunbar, "Gratuity, Embodiment, and Reciprocity," *Journal of Religious Ethics* 41 (2013): 256.
[119] Eva Feder Kittay, *Love's Labors: Essays on Women, Equality and Dependency*, 2nd ed. (New York: Routledge, 2020), 71.
[120] Kittay, "When Caring is Just and Justice is Caring," 273.

discovered territories of human capabilities, highlighting the contribution of care receivers to their caregivers and relationships. Cushing and Lewis conclude from their research that people with disabilities possess traditionally less-attended-and-praised qualities of "welcome, wonderment, spontaneity, and directness… unity through their simplicity and vulnerability," by which their caregivers gain a new perspective of the meaning of human ability.[121] Although celebrating and crediting the unappreciated capacities of those with intellectual disabilities is possible only under specific circumstances and efforts, their findings reveal that people with dependency still have the capacity to make positive and constructive impacts on others. Feminist epistemology's interest in human emotions encourages the discovery of human affective capacities rather than focusing exclusively on cognitive abilities.[122] However, it is worth noting that the goal holds two contradicting truths. One is that, at the core of the barriers preventing the validation and affirmation of the capacities of people who function differently, there are epistemic injustices that limit our perceptions and imaginations, constraining them to narrow, traditional views and norms of human experiences with mental distress. On the other hand, the other truth is that the distress, struggles, and burdens experienced both by those living with and caring for individuals experiencing schizophrenia, which have impeded its validation and affirmation so far, should not be taken lightly or disregarded in pursuit of the alternative approach.

Feminist scholars also show interest in care relationships, especially the concept of mutuality as a potential relational resource to utilize. Kittay argues that people share the universal, inherent experience of being "some mother's child"—individuals who were once

[121] Pamela Cushing and Tanya Lewis, "Negotiating Mutuality and Agency in Care-Giving Relationships with Women with Intellectual Disabilities," *Hypatia* 17, no. 3 (2002): 182.

[122] Tuana, "Feminist Epistemology," 128.

cared for and nurtured for their survival. This shared experience is the foundation for feeling connected to others and being willing to offer care when others need help.[123] She further asserts that dependency is a universal human condition unexceptionally shared by all. While some dependencies, such as severe mental disabilities, are "hypervisible," many of our dependencies on others are only hidden.[124] Mutuality stems from this mutual dependence as the shared human experience that makes a universal moral responsibility to care for others possible, thus motivating people to participate in caring for those in need. Nevertheless, applying this concept to the care of individuals with schizophrenia, given its strong association with stigma and fear, as well as the specific difficulties and distresses arising from people's lived experiences, remains a conundrum for this project, different from Kittay's context.

Cushing and Lewis offer another example of mutuality, an essential ingredient for fostering more equal and just care. "Relational mutuality" refers to building "mutually beneficial relationships" that "encourage relational connections while acknowledging and negotiating the terms and limits of the power imbalances structuring those relations."[125] According to Cushing and Lewis, "for mutuality to be present, the socially constructed inequities between these women [caregiver and care receiver] must be acknowledged and named by those in the stronger position."[126] Only after that is the mutual trust between the two, whose social locations and powers are different, established for achieving relational mutuality.[127] To overcome the power asymmetry and subsequent conflicts inherited and situated in caring relations, Cushing and Lewis recommend that sharing and negotiating "power not only within their relationship but also

[123] Kittay, *Love's Labor*, 73-75.
[124] Kittay, "When Caring is Just and Justice is Caring," 267-68.
[125] Cushing and Lewis, "Negotiating Mutuality and Agency," 174.
[126] Cushing and Lewis, "Negotiating Mutuality and Agency," 180.
[127] Cushing and Lewis, "Negotiating Mutuality and Agency," 184-86.

in the decisions is required."[128] Through this relational mutuality, caregivers finally learn from care receivers' unique capacities to communicate, affect, and contribute to others beyond what traditional understanding defines as human capacities, thus reshaping their views on life, including values and goals.[129] While this argument is echoed by that of Mad Studies, intending to assign more agency and power to people with lived experience of mental illness in their decisions over treatment and life choices, the consideration of exceptional cases should be included—for example, when individuals are not in the state to choose more healthy, self-rewarding, safe choices, and consequently behaving dangerously to oneself or others.

At the same time, we have to be mindful that the concept of mutuality entails risks of misinterpretation or misuse, which may incur more harm or confusion. Cushing and Lewis's advice is to take heed of vulnerabilities within the mutuality by sharing and negotiating power, especially when carers' care tasks are directly related to care receivers' safety.[130] Feminist pastoral theologian Bonnie Miller-McLemore warns of cases of mutuality being "ill defined and sloppily understood," describing the famous debate about boundaries in therapy around Carter Heyward's controversial book *When Boundaries Betray Us*.[131] Miller-McLemore points out that in the debate, different authors make arguments premised on different definitions of mutuality without consensus per one's context; the definitions vary as 1) "shared power and agency," 2) "equal regard or respect," 3) "sexual and emotional intimacy;" 4) "shared responsibilities;" and 5) "just love."[132] Given plural meanings of the concept, drawing upon cases of adult parent-child relationships, Miller-McLemore argues that mutuality needs to be carefully employed in

[128] Cushing and Lewis, "Negotiating Mutuality and Agency," 187.
[129] Cushing and Lewis, "Negotiating Mutuality and Agency," 183-89.
[130] Cushing and Lewis, "Negotiating Mutuality and Agency," 186.
[131] Bonnie Miller-McLemore, "Sloppy Mutuality: Just Love for Children and Adults," in *Mutuality Matters: Family, Faith, and Just Love*, ed. Herbert Anderson et al. (Lanham: Rowman & Littlefield Publishers, 2004), 121-35.
[132] Miller-McLemore, "Sloppy Mutuality," 126-27.

consideration of differences and inequities within each individual and relationship, according to each party's development, maturity, abilities, needs, and the obstacles, risks, and failures in the relationship.[133] Her analysis resonates with the finding of pastoral theologian Jonna M. P. Ojalammi's research on the partner's view of a spouse with mental illness. Ojalammi argues that the key to surviving and thriving for the spouse of a person with mental illness in their marriage is to communicate with and rely on the relational self and appreciate and commit to the unchangeable true self of his/her partner.[134] Seeking mutuality should be done with an awareness of the limitations and disparities inherent in an inevitable asymmetrical care relationship, especially considering the history of vulnerabilities and weaknesses that have been shaped over time. Applying the concept of mutuality to research on spiritual care for schizophrenia requires serious consideration of this aspect, as both caregivers and care receivers often find themselves in vulnerable positions, albeit in their distinct ways. For instance, ensuring the safety of both parties becomes paramount, especially in cases where there is no prior history of observing or living with the person to identify potential signs of harm or danger. At the same time, a compassionate approach is essential to understanding people's histories and the reasoning behind their delusional or hallucinatory experiences. Without falling into the trap of mental illness essentialism or reductionism, recognizing these limitations and vulnerabilities is essential if we strive for the challenging yet attainable goal of achieving mutuality.

Lastly, the contribution of feminist studies to the discussion of care revolves around the issue of justice for caretakers. Without appropriate compensation for caregivers for their non-care-related life, along with providing essential resources and support for their caregiving tasks,

[133] Miller-McLemore, "Sloppy Mutuality," 127-33.

[134] Jonna M. P. Ojalammi, "Who Am I Committing to, Who Am I Forgiving? – How Spouses View the Personhood of Their Partner Living with Mental Illness," *Journal of Pastoral Theology* 29, no.2 (2019): 8, https://doi.org/10.1080/10649867.2019.1629732.

the improvement of care procedures and outcomes cannot be anticipated. Research from feminist scholars highlights the correlation between the wellbeing of care receivers and caregivers.[135] For the same reason, as Kittay points out, neither a caregiver nor a dependent person can call for justice in the occurrence of injustice during caring unless it is supported by others or society.[136] The issues of justice for those caring for other human beings guide me to acknowledge the anticipated realistic and practical difficulties derived from caregiving works. Throughout my dissertation research on spiritual care for individuals with schizophrenia, I have remained mindful of these realities.

The discussion of feminist studies on justice for caregivers extends to the social level, given their strong emphasis on changing society's awareness and treatment of caregivers and caring relationships. This includes the active participation of the community and society in sharing caregivers' burdens and supporting them and caring relations in various ways as a significant social and political issue. Kittay claims that the need for care and the obligation to provide care are universal human rights/duties and that society must assume a more significant role in providing support that creates "a linked and nested set of social relations."[137] Based on her idea of "connection-based equality," Kittay argues that caregivers' care must be reciprocated not only by care receivers but, when available, from those who are located in "a nested set of reciprocal relations and obligations," which Kittay calls "*doulia*."[138] For caregivers' support, Kittay includes "appropriate training, the opportunity to grow in their work, a voice in the care of their charges, compensation that matches the intensity of their labor, and encouragement in their

[135] Kittay, *Learning from My Daughter*; Cushing and Lewis, "Negotiating Mutuality and Agency;" Joan C. Tronto, *Caring Democracy: Markets, Equality, and Justice* (New York: New York University Press, 2013).
[136] Sullivan-Dunbar, "Gratuity, Embodiment, and Reciprocity," 264.
[137] Kittay, *Love's Labor*, 73; 121.
[138] Kittay, *Love's Labor*, 73.

sympathetic and empathic responses to their charges."[139] To prevent their sacrificial love in caring from being exploited, caregivers should have "access to the power, financial capacity, and social respect."[140]

This also means a drastic change in awareness on a social level. For example, despite the positive aspects of women's participation in domestic care performed by culturally constructed feminine virtues throughout history, these virtues alone are insufficient to address the perpetuation of injustices, such as under-compensation and social discreditation, in performing their tasks. Due to the domestication of care values, informal women care workers frequently bear the inequality embedded in being disproportionately assigned to caregiving tasks at home, both caused by and contributing to further injustice such as underestimation and marginalization of women that pervades across society.[141] Therefore, Joan Tronto makes a bold but legitimate claim that, to create the democratic care revolution that acknowledges equal participation in caring from both genders, "we need to change values, institutions, and practices about the relationships of masculinity (and, by extension, femininity) and care.[142] The discussions in Feminist Studies about social and public assistance, in terms of justice to caring relations, inspire us to adequately reorganize and reassign caring burdens in the spiritual care of people with schizophrenia within the Korean church context to lighten the caring burdens of families and clergy.

Disability Theology

Along with the growing body of scholarship on disability, disability theology has

[139] Kittay, "When Caring is Just and Justice is Caring," 270.

[140] Don S. Browning, Bonnie J. Miller-McLemore, Pamela D. Couture, K. Brynolf Lyon, Robert M. Franklin, eds., *From Culture Wars to Common Ground: Religion and the American Family Debate*, 2nd ed. (Louisville, Ky: Westminster John Knox Press, 2000), 284-85.

[141] Tronto, *Caring Democracy*, 67-94.

[142] Tronto, *Caring Democracy*, 69.

generated pioneering works that integrate theological constructions with the lived experiences of people with disabilities, which were neglected and silenced for too long in traditional Christian theology. Disability theology unearths the unheard voices of people with disabilities within the scriptures and the church by focusing on how the reality of their lives resonates or dissonates with the teachings of Christianity and reconstructing them to be congruent with each other. Like Mad Studies and feminist studies, disability theology holds the potential to offer a novel perspective on considerations for envisioning more creative, equal, and liberating spiritual care for people with mental disabilities, including schizophrenia. The lens of disability studies, in particular, can illuminate three critical aspects of spiritually caring for individuals with mental disabilities: epistemology, the community's role, and distributive justice.

One of the incomparable strengths of disability theological studies lies in its endeavor to redirect the epistemic perspective from the predominantly non-experiential constructs of traditional Christian theology of disability to the viewpoints of individuals living with disabilities. This shift is integral to the reconstruction of religious and spiritual understandings and the meanings associated with related life experiences. In her monumental book *The Disabled God*, Nancy Eiesland turns to Rebecca Chopp's "critical praxis correlation" model, which criticizes David Tracy's "revised critical correlation" model for its universalizing "common human experiences" by excluding the experiences of those who are deemed as disabled.[143] Instead, Eiesland's use of the critical praxis correlational method and "liberatory theology of disability" presents ways to reconstruct oppressive, exclusive, and irrelevant Christian theology and religious practices into ones that are more emancipatory, inclusive, and relevant to groups living with disabilities: "deliberate recognition of the lived experience of persons with disability,

[143] Nancy L. Eiesland, *The Disabled God: Toward a Liberatory Theology of Disability* (Nashville: Abingdon Press, 1994), 21.

a critical analysis of a social theory of disability and certain aspects of the church's institutional practices and Christian theology, and the proclamation of emancipatory transformation."[144] Eiesland also highlights the significance of searching for "alternative structures and symbols of religious life that can effectively challenge oppressive beliefs and values [embedded in the existing theology and practices]."[145] Disability theology provides a new epistemic lens that calls for a new religious/spiritual language and descriptions derived from the narratives of those with lived experiences. The new language is highly crucial for portraying and appreciating the nuanced spiritual meanings of living with schizophrenia, as well as envisioning an unconventional portrayal of spiritual life based on language and descriptions. In other words, the more relevant, genuine, and self-determining these voices, the more impactful, liberating, and empowering they become in shaping the meanings and decisions of individuals with schizophrenia, influencing their secular and faith life.

In shifting the perspective on disability, the efforts to redefine the nature of what people with mental disabilities have experienced, bringing it closer and making it more genuine in relation to people's realities, require a more specific approach that pinpoints subtle differences among diverse disabilities. For example, critical disability studies can guide theologians in advancing their theological works on people with mental disabilities by offering an alternative perspective rather than uncritically adopting the existing social model of disability, which was previously based on the lived experiences of physical and sensory disabilities. Disability studies scholar Donna Reeve redefines the social model of disability to make it better-suited to the specific context of people diagnosed and living with mental illness. The existing social model distinguishes between "impairment" and "disability," with impairment referring to the damage or

[144] Eiesland, *The Disabled God*, 22.
[145] Eiesland, *The Disabled God*, 99.

defacement in one's physical, cognitive, affective, or social capacity. In contrast, disability means sociocultural and systemic barriers that create disturbance and disruption for people with the impairment.[146] Reflecting on the contexts of people with mental illness/disability that are different from those of people with physical or other sensory disabilities, Reeve adds the notion of "mental distress" to explain another dimension of the lived experiences of people with mental illness.[147] Distinguishing it from an impairment, Reeve uses the term mental distress to describe people's emotional or mental experiences, which are different from "societal norms of behaviour."[148] Instead of seeing people's experiences with mental illness solely as being impaired or debilitated, the revised model acknowledges the possibilities for people to exist and live differently with their mental or emotional experiences. Reeve also refines the concept of disability into "structural disablism" and "psycho-emotional disablism," where the latter term refers to unjust social prejudices and treatments of disability on a personal level, which "undermine someone's psycho-emotional wellbeing and sense of self" on the experiences of mental distresses in social contexts.[149] The revised social model of mental disability can lay out an alternative perspective to distinguish the complicated experiences of living with schizophrenia among being different, impaired, and disabled on various levels, which creates more room for spiritual care to intervene.

Disability theology also urges faith communities to reconsider their roles concerning people's mental distress: moving from charity to advocacy. Traditional Christian theology has frequently depicted people with disabilities as lacking the capabilities to be considered whole

[146] Donna Reeve, "Psycho-Emotional Disablism in the Lives of People Experiencing Mental Distress," in *Madness, Distress and the Politics of Disablement*, ed. Helen Spandler, Jill Anderson, and Bob Sapey (Bristol: Policy Press, 2015), 99-100.

[147] Reeve, "Psycho-Emotional Disablism in the Lives," 103-04.

[148] Reeve, "Psycho-Emotional Disablism in the Lives," 104.

[149] Reeve, "Psycho-Emotional Disablism in the Lives," 100-03.

human beings.[150] Paradoxically, this portrayal has sustained the survival of these individuals through devoted engagement in faith-driven charitable acts within and outside the church.[151] However, the imbalanced caring relationship rooted in the traditional Christian theological understanding of disabilities, particularly mental disabilities, and the resulting practice of charity towards those identified with their disabilities falls short of empowering and liberating these groups of people with lived experiences, given the various levels of social injustices imposed on them.[152] On the other hand, the church can be a place of proactive inclusion, empowerment, and liberation, given the teachings of religion, especially Christianity, reflecting its genuine intention for the complete acceptance, healing, and salvation of people experiencing oppression due to their differences, particularly as emphasized by disability theologians.[153]

Lastly, disability theology encourages the church to reassess the current distribution of resources specifically allocated to the care of individuals with disabilities. Distributive justice refers to the "moral guidance for the political processes and structures that affect the distribution of benefits and burdens in societies," impacting the lives of their members.[154] On both an individual and collective level, those living with disabilities have often experienced silence and marginalization in discussions regarding the allocation of community resources—whether within specific communities or society at large.[155] In South Korea, rather than being recognized as

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[150] Deborah Beth Creamer, *Disability and Christian Theology: Embodied Limits and Constructive Possibilities*, Academy Series (Oxford; New York: Oxford University Press, 2009), 43-4; Doreen Freeman, "A Feminist Theology of Disability," *Feminist Theology* 10, no. 29 (January 2002): 78, https://doi.org/10.1177/096673500200002907.

[151] Freeman, "A Feminist Theology of Disability," 78.

[152] Thompson, "Ableism," 236-40.

[153] Thompson, "Ableism," 242-47; Thomas E. Reynolds, *Vulnerable Communion: A Theology of Disability and Hospitality* (Grand Rapids, Mich: Brazos Press, 2008), 219-32; Sarah Jean Barton, *Becoming the Baptized Body: Disability and the Practice of Christian Community*, Studies in Religion, Theology, and Disability (Waco, Texas: Baylor University Press, 2022), 121-37.

[154] Julian Lamont and Christi Favor, "Distributive Justice," *Stanford Encyclopedia of Philosophy*, September 26, 2017, https://plato.stanford.edu/entries/justice-distributive/.

[155] Daniel Putnam et al., "Disability and Justice," *Stanford Encyclopedia of Philosophy*, July 2, 2019, https://plato.stanford.edu/entries/disability-justice/.

active stakeholders, individuals with various types of disabilities have long been perceived primarily as passive recipients of social and religious assistance, which includes care to meet their basic needs and various accommodations tailored to their specific requirements for survival.[156] This situation extends to Korean churches. The issue of distributive justice in faith communities implies that the membership of individuals with disabilities in religious or spiritual communities has not been fully acknowledged or affirmed, given their limited influence on decisions regarding various resources under the purview of the church. People living with disabilities experience a denial of full membership in the church compared to those without disabilities. This leads to a sequential inequitable allocation, often justified by the imperative of maintaining efficiency in resource utilization for the greater good of the majority.[157] Therefore, reflecting on the issue of distributive justice, particularly envisioning the fair allocation of church resources for the care of people with mental disabilities, such as schizophrenia, can spark a chain of discussions on the essence and missions of faith communities. These discussions can delve into whom they embrace and live with and how to care for individuals genuinely and effectively within and beyond the community. Not only does this approach enable the inclusion and empowerment of populations with disabilities inside the community of faith, but it also serves to rejuvenate and recommit those without firsthand experience to their faith and its practice.[158] The three implications of disability theology offer this research project a counterweight to the currently predominant options and values chosen in the spiritual care of people with mental

[156] Celeste L. Arrington, "Disabled People's Fight for Rights in South Korea and Japan," *Current History* 120, no. 827 (September 1, 2021): 233–39, https://doi.org/10.1525/curh.2021.120.827.233.

[157] Seoksoon Shim, "Factors Influencing the Attitudes of Church Members with Non-Disabilities toward Church Members with Disabilities in the Church," *Korean Journal of Christian Studies* 123 (January 31, 2022): 339, https://doi.org/10.18708/kjcs.2022.1.123.1.337.

[158] Barton, *Becoming the Baptized Body*; Reynolds, *Vulnerable Communion*, 181-85; John Swinton, *Becoming Friends of Time: Disability, Timefullness, and Gentle Discipleship* (Waco, TX: Baylor University Press, 2016), 208.

disabilities in the Korean church to find a middle ground, which will be discussed in more detail in the later chapters. This is because, as mentioned earlier, ministers and churches in South Korea often demonstrate a tendency for spiritual care decisions that commonly and easily lean towards more realistic, efficient options, favoring the needs of the majority without disabilities, without sufficient deliberation on the complicated justice issues involved.

Intercultural Spiritual Care

Inspired by the intercultural paradigm of pastoral care coined by another pastoral theologian, Emmanuel Y. Lartey, integrating with narrative and contextual approaches, pastoral theologian and psychologist Carrie Doehring presents the intercultural spiritual care paradigm as the "cocreative process [between caregiver and care receiver] of intermingling stories that take into account the interacting multilayered stories of people embedded in overlapping familial, communal, and social systems."[159]

Doehring's intercultural approach to spiritual care is based on the premise that, besides doctrinal or religious beliefs taught by one's religion, people initially construct their "embedded theology" out of their early life experiences significantly influenced by primary relationships and environments, which often generate fragmented, emotionally charged, and unhealthy and "life-limiting" responses in the face of loss, crisis, and trauma.[160] Therefore, the provision of spiritual care based on this approach aims to help its care seekers build an "intentional theology." Intentional theology, also formulated out of individual's personal experiences but more consistent and integrated with their religious/spiritual values, promotes constructive and compassionate understandings and emotions/ideas about God and oneself and is flexible and complex enough to support and empower people to be resilient amid suffering, as "life-

[159] Doehring, *The Practice of Pastoral Care*, 188.
[160] Doehring, *The Practice of Pastoral Care*, 4-5; 18-19.

giving."[161] To determine whether an individual's theology is life-giving or life-limiting, Doehring presents the four assessment criteria of "spiritual orienting systems," a concept that refers to a person's whole gamut of religiosity/spirituality, developed by psychologist Kenneth Pargament:

- Differentiated meaning-making complex enough to bear the weight of suffering
- Integration of one's values, beliefs, and practices
- Flexibility in how one spiritually copes with stress
- Beliefs and spiritual practices related to the goodness of life/God's goodness that foster self-compassion and compassion.[162]

Other vital concepts employed in the approach, such as "self-reflexibility" and "theological-reflexibility," guide to acknowledge how spiritual caregivers' own and care receivers' embedded and espoused theologies are shaped by respective relational and social matrices and theological experiences and their influences, including social privileges and disadvantages.[163] In the context of my dissertation, both concepts assist me in exploring my embedded and espoused theologies of schizophrenia, along with the respective theologies of my interviewees. Especially with self and theological reflections, I examine the impacts and influences of my cultural context, specifically cultural and religious sanism, on forming my religious/spiritual beliefs, values, and practices. This examination will be presented in the following Chapter 3.

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy is one of the later generations of Cognitive Behavioral Therapy (CBT), which proposes an advanced approach to address an individual's emotional or behavioral difficulties, initially targeting the population who are diagnosed with borderline personality disorder. DBT was developed by psychologist Marsha Linehan, who also has a

[161] Doehring, *The Practice of Pastoral Care*, 11-12; 17-18.
[162] Doehring, *The Practice of Pastoral Care*, 90.
[163] Doehring, *The Practice of Pastoral Care*, 191-92.

personal experience of psychiatric inpatient treatment for her suicidality. Linehan believes emotions are formed and experienced by and under various human processes. More than just an outcome of the cognitive evaluation process, Linehan postulates that emotions originate from intertwined and mutually-influential human processes among "cognitive-verbal," "motoric" (behavioral), "physiological," and affective systems, which she calls "full-system responses," and they need to be responded to in various ways in their effective regulation.[164] Linehan also highlights that among borderline personality disorder patients, there exist individual differences in people's lived experiences even under the same diagnosis. She attributes the differences to an individual's unique biological and social contributions to their emotional vulnerability.[165] Based on this theoretical underpinning, the "biosocial theory" of emotion, DBT adopts an approach that refrains from attributing an individual's excessively negatively experienced or expressed emotions or behaviors solely to irrational, distorted cognitive evaluation processes or mere neurophysiological causes.[166] Furthermore, DBT goes further to propose an alternative perspective on patients' actions or decisions, previously considered harmful and counterproductive. That is, those behaviors identified as problematic and dangerous have their validity, benefits, and values in serving the individual's effort to balance the status quo under their mental distress.[167] In other words, understanding emotions and behaviors needs to be placed in a broader perspective for comprehensive comprehension rather than focusing solely on their immediate consequences.

This shift in perspective both necessitates and leads to a groundbreaking approach for individuals whose problems are paradoxical and dilemmatic. Therefore, alongside DBT's

[164] Linehan, *Cognitive-Behavioral Treatment*, 38.
[165] Linehan, *Cognitive-Behavioral Treatment*, 41.
[166] Linehan, *Cognitive-Behavioral Treatment*, 38.
[167] Linehan, *Cognitive-Behavioral Treatment*, 208.

biosocial understanding of emotional distress, another core tenet of DBT offers guidance for effectively and holistically addressing dilemmas continuously encountered during therapy and in an individual's daily life: dialectics. Recognizing the dialectical nature of reality as interrelated and ever-changing and containing ongoing tension between valid possibilities on opposing poles,[168] DBT's treatment modality follows a unique approach to addressing people's emotional vulnerability with flexible, diversified, and immediate strategies to attend to their experiences of emotional instability. DBT adopts a modular model consisting of four skill modules in mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation,[169] structured in individual, group, remote, and team settings.[170] Although the ways treatments are delivered vary depending on each client's issues and contexts, all DBT therapy actions implemented should be based on the therapist's awareness of the ongoing dilemmatic tension between validating the patients through the acceptance of their current status quo and encouraging them to seek change to improve their lives.[171] Therefore, seasoned DBT practitioners recommend embracing and incorporating fundamental dialectical principles into their therapy orientation.

- Maintain a dialectical worldview.
- Balance and synthesize positions, strategies, and styles.
- Accept natural change.[172]

Conclusion

The extensive review of various literatures relevant to people's lived experience of schizophrenia reminds us once again that the reality of people's lives and sufferings is neither monolithically, exclusively limited to a simplistic spiritual equation with curse or punishment,

[168] Alexander L. Chapman and Katherine L. Dixon-Gordon, *Dialectical Behavior Therapy*, Theories of Psychotherapy Series (Washington, DC: American Psychological Association, 2020), 38-39.
[169] Chapman and Dixon-Gordon, *Dialectical Behavior Therapy*, 74.
[170] Chapman and Dixon-Gordon, *Dialectical Behavior Therapy*, 68.
[171] Chapman and Dixon-Gordon, *Dialectical Behavior Therapy*, 39.
[172] Chapman and Dixon-Gordon, *Dialectical Behavior Therapy*, 40.

nor to the experiences defined as symptoms by psychiatry and its descriptions. In order to comprehensively understand and keenly attend to the various layers of each individual's distinctive lived experiences of schizophrenia, shaped under the intersections of diverse sociocultural contexts of care seekers and caregivers, the next chapter will review the methods and methodology used in collecting the narratives of seven Korean pastors' spiritual care interactions with individuals experiencing schizophrenia in the churches they served.

Chapter 3

Methods and Methodology

Introduction

My dissertation is shaped by drawing on three methodologies: 1) critical narrative inquiry supplemented by Alecia Y. Jackson and Lisa A. Mazzei's "thinking with theory"; 2) Carrie Doehring's intercultural spiritual care approach; and 3) a psychotherapeutic treatment model, Dialectical Behavior Therapy (DBT). These approaches assist me to critically examine the spiritual caregiving experiences of Korean Protestant pastors working with individuals diagnosed with schizophrenia within the church. Specifically, I focus on 1) the sanist, limited embedded theologies related to the lived experience of schizophrenia, as held by seven Korean pastors in their pastoral practice context; and 2) the various types of dilemmatic experiences encountered by these pastors.

I argue that the purpose of this research is well-served by critically engaging with both the expressed and silenced aspects of research participants' narratives. These methodologies, with their shared deconstructive nature toward reality, enable me to take a critical look at the research participants' theological assumptions of pastoral care and the various dilemmas they faced during their pastoral care encounters with the individuals identified with schizophrenia. Critical narrative inquiry helps revisit how pastors interacted with individuals with schizophrenia, allowing us to examine the theological rationales of pastoral care they provided, which were shaped by various contextual influences, especially sanism. Using the critical narrative inquiry method is also expected to uncover underappreciated/neglected meanings and values associated with the unchosen caring options that could have been considered if alternative theological deliberations had been undertaken. This research is also guided by Alecia Y. Jackson

and Lisa A. Mazzei's "thinking with theory," by which the collected narrative data undergo critical interpretive scrutiny with two key theoretical concepts: sanism and dialectics. Through an analysis of the pastors' embedded theology and its formative and contributory factors, the intercultural spiritual care approach proposed by Carrie Doehring also assists to explore the underlying religious and spiritual beliefs and values that resulted in their practice of pastoral care. Their life-limiting theological beliefs and values, in turn, determined or constrained the pastoral care practices of the pastors based on what they perceived as most available and adequate during the pastoral encounters. In Chapter 8, as a conclusion, I borrow and revise the three phases of planning intercultural spiritual care—the stages formulated by Doehring as she received inspiration from the works of Judith Herman and Marie Fortune.[1] This revision reflects considerations aimed at creating a critical pastoral care model better suited to the specific needs of individuals involved in providing and receiving spiritual care for schizophrenia.

Utilizing one of the core principles of DBT—dialectics—leads to envisioning a synthesis of opposing care choices in each dilemma in the spiritual care practice for schizophrenia, recognizing the validity in both. Dialectics facilitate a comprehensive and realistic reflection process that considers the sufferings, burdens, costs, challenges, and limitations, as well as the benefits, potentials, and untapped values and resources in choosing a contextually-informed, pragmatic, flexible yet empowering and liberating spiritual care approach for both spiritual caregivers and individuals with lived experience of schizophrenia within and beyond the Korean church. In briefly explaining the qualitive interview research process, my location as a researcher will be presented to highlight how it affect my interviewing with research participants'

[1] Doehring, *The Practice of Pastoral Care*, 173.

experiences as well as my interpretation of the data and the overall research process.

Critical Narrative Inquiry

To analyze the empirical data gathered from individual interviews, I employ the critical narrative inquiry approach, deemed suitable for conducting a comprehensive exploration of Korean pastors' understandings of schizophrenia concerning the narrated stories of their pastoral experiences with individuals with schizophrenia in the churches.

As a method for qualitative research, narrative inquiry aims to study the meanings of the lived experiences of research participants shared as a form of stories.[2] The definition of narrative has evolved throughout its development as a research method, reflecting the debates and contributions of the researchers incorporating it into their scholarship.[3] After a thorough review of discussions surrounding how to define it, Susan E. Chase presents the following expanded working definition of narrative:

> A *personal* narrative is a distinct form of *communication*: It is meaning-making through the shaping of experience; a way of understanding one's own or others' actions; of organizing events, objects, *feelings*, or *thoughts* in relation to each other; of connecting and seeing the consequences of actions, events, *feelings*, or *thoughts* over time *(in the past, present, and/or future)*.[4]

The expanded concept effectively captures its methodological strength in keenly attending to the interrelatedness of various dimensions of the storyteller's experience, both intrapsychic and outer life, revealed through analysis. It resonates with D. Jean Clandinin's arguments that the interests of narrative inquiry lie in validating the storyteller's narratives and in explicating the "larger social, cultural, familial, linguistic, and institutional dimensions" of its formative context.[5]

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[2] Creswell and Poth, *Qualitative Inquiry & Research Design*, 68.

[3] Susan E. Chase, "Narrative Inquiry: Toward Theoretical and Methodological Maturity," in *The SAGE Handbook of Qualitative Research*, 5th ed., ed. Norman K. Denzin and Yvonna S. Lincoln (Los Angeles: SAGE, 2018), 547-48.

[4] Chase, "Narrative Inquiry," 549. Italics in original.

[5] Creswell and Poth, *Qualitative Inquiry & Research Design*, 75.

The deconstructive nature of this method allows for pursuing these interests by delving beyond the expressed narratives. Postmodern elements integrated into the narrative inquiry approach, involving "deconstruction of the stories, an unmaking of them by such analytic strategies as exposing dichotomies, examining silences, and attending to disruptions and contradictions,"[6] enable the critical analysis of interwoven, paradoxical, and overlooked layers within the narratives.

Finally, narrative inquiry's emphasis on promoting social justice through research is attractive to many researchers, including myself, as it promises to yield academic and practical advancements of justice issues in the specific fields of respective research.[7] For instance, the approach's aim of empowering research participants is achieved through the process of participants "restorying" their experiences and the resulting reconstructed narratives.[8] Given the mentioned features, narrative inquiry is considered advantageous for my dissertation because the study's object is to examine the pastors' theology of schizophrenia, their formative sanist influences, and the various dilemmas they encounter, to propose strategies to overcome these challenges for benefiting both caregivers and care receivers.

However, as I review narrative inquiry as a qualitative research method in line with the goals of my dissertation, I identify particular necessities for critically analyzing the narratives on specific theoretical foundations. First, the study necessitates thoroughly examining pastors' beliefs and values in spiritual care, which were often unchallenged and accepted without resistance. One focus of critical narrative analysis is to reexamine widely accepted discourse with an awareness of the socio-temporal and spatial limits of one's subjective knowledge: "[t]he

[6] Creswell and Poth, *Qualitative Inquiry & Research Design*, 72.
[7] Chase, "Narrative Inquiry," 555-56.
[8] Creswell and Poth, *Qualitative Inquiry & Research Design*, 68.

taken-for-granted or tacit knowledge is also an important concept delving into storytelling, exploring issues that are not stated, issues that are assumed, and issues that are common sense."[9] In their pastoral interactions with individuals living with schizophrenia, their responses were rooted in their pre-reflected theological understandings of schizophrenia and the spiritual care of people who live with it—the embedded theological beliefs and practices—which have been learned and shaped by various prejudicial and discriminatory influences stemming from their personal, educational, sociocultural, and theological contexts. This tendency frequently leads to moments of dilemma as pastoral caregivers grapple with the perceived and anticipated limitations of their capabilities, roles, boundaries, and available resources. Understanding how these diverse contextual influences, including sanism, shape their theology represents the initial step toward envisioning how to address the dilemmas encountered and expanding our capacity for imaginative spiritual care in the pursuit of better spiritual care.

Second, by uncovering elements pastors may have overlooked or not fully grasped during their experiences, the dissertation aims to identify alternative caring options to those chosen by the pastors in the specific dilemmas they encountered while providing spiritual care. This work includes exploring potential approaches that could have been taken if different spiritual care diagnoses and considerations of the pastors and their care receivers' needs and contexts had been conducted. Discovering these uncharted paths of caring options and decisions from their narratives demands delving deeper than what was explicitly expressed in the interviews. This process entails examining not only what pastors have articulated in their theological reasoning but also what may have remained unrecognized, dismissed, or rejected by them in justifying

[9] Lisbeth A. Pino Gavidia and Joseph Adu, "Critical Narrative Inquiry: An Examination of a Methodological Approach," *International Journal of Qualitative Methods* 21 (January 2022): 5, https://doi.org/10.1177/16094069221081594.

spiritual care offered to individuals with schizophrenia.

Last but most importantly, the study needs to complement the unheard voices of people with lived experience of schizophrenia in the church not directly included in the research. Although one of the main ideas of this dissertation is to encourage listening to the lived experiences of people with schizophrenia, their participation in the interview has not been included due to the limitations of this research. However, the voice left out in the research ironically appeals to the change of spiritual care for more inclusion and validation of those voices of lived experiences. My analysis and construction of meanings as a co-creating of meanings out of stories shared as a researcher[10] aims to present silenced, unattended voices in the interviews from the other end of pastoral care. Reflecting on the unheard voices will be applied to finding the complicated nature of the experiences and the uncharted path of caring.

To meet these research needs, I integrate the narrative research approach, utilizing the analytical process called "thinking with theory," developed by Alecia Y. Jackson and Lisa A. Mazzei, in addition to the traditional thematic analysis of narrative research coding.[11] Criticizing the temptation to find coherence in data by ignoring multiplicities/complexities in narratives, Jackson and Mazzei suggest acknowledging the partialness and incompleteness of data and the possibilities of diverse analyses out of the same data.[12] Jackson and Mazzei introduce the concept of "plugging in," by which they propose leading the research process "as a production of the new, *the assemblage in formation*," by connecting "a field of reality (data, theory, method),"

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[10] Creswell and Poth, *Qualitative Inquiry & Research Design*, 72.

[11] Womanist pastoral theologian Jessica Chapman Lape offers a brilliant example of theological writing adopting the "thinking with theory" approach in her narrative analysis in addressing the limitations of the traditional narrative approach; See Jessica Chapman Lape, "*Miss*Treated: A Womanist Clinical Pastoral Theology on African American Women's Mistreatment in U.S. Healthcare," PhD diss., (Claremont School of Theology, 2021).

[12] Alecia Y. Jackson and Lisa A. Mazzei, "Plugging One Text into Another: Thinking with Theory in Qualitative Research," Qualitative Inquiry 19, no. 4 (April 2013): 261-62, https://doi.org/10.1177/1077800412471510. See also Jackson and Mazzei, *Thinking with Theory in Qualitative Research*, 1-14.

"a field of representation (producing different knowledge, resisting stable meaning)" and "a field of subjectivity (becoming-researcher)."[13] The thinking-with-theory approach equips me to guide my research through "multiplicity, ambiguity, and incoherent subjectivity" among pastoral caregiving narratives in terms of caring for schizophrenia within the "reading-the-data-while-thinking-the-theory" moments that lead to "something new" about the data and theories.[14] With the three maneuvering strategies of plugging in, 1) disrupting theory/practice binary, 2) being deliberate and transparent in forming and using analytical questions based on specific theoretical concepts throughout the process, and 3) "working with the same 'data chunks' repeatedly to 'deform [them], to make [them] groan and protest'… with an overabundance of meaning,"[15] this thinking with theory approach clarifies/resolves/transforms my own suspicion and dilemma torn between affirming madness experiences and addressing distress and disturbance caused by them in my tri-dialogue among researchers, data, and theory.

The first cycle of data analysis involves a thematic analysis process that categorizes the pastors' understanding and experiences of pastoring people with schizophrenia, including the various types of dilemmas they face in their caregiving experiences. Subsequently, the second analysis cycle comprises a deliberate critical examination of the narratives, integrating two theoretical frameworks: 1) sanism overtly and covertly shown in Korean society and the Korean Protestant church, and 2) the dialectics of synthesizing opposing choices embedded within the dilemmas encountered in spiritual caregiving situations.

Intercultural Spiritual Care

Doehring's intercultural spiritual care approach holds significant potential for enhancing

[13] Jackson and Mazzei, "Plugging One Text into Another," 263.
[14] Jackson and Mazzei, "Plugging One Text into Another," 264.
[15] Jackson and Mazzei, "Plugging One Text into Another," 264.

pastoral caregiving for individuals with lived experiences of severe mental illness, with a specific focus on schizophrenia in this dissertation. The approach's five characteristics can contribute to effectively meeting the needs of both the direct and indirect populations affected by one's own or others' lived experience of schizophrenia, as well as their spiritual caregivers.

First, the model provides a theoretical framework for analyzing the multifaceted layers of embedded and intentional theology among pastoral caregivers and care receivers. This analysis encompasses various dimensions, including cognitive, affective, behavioral, relational, sociocultural, and spiritual aspects, as well as different layers of meaning, such as personal and familial, intrapsychic, interpsychic, and extrapsychic, religious/spiritual, communal, sociological, and global. According to Doehring, spiritual caregivers are equipped with the training and knowledge to switch between different lenses—premodern, modern, and postmodern—and languages—precritical, critical, and post-critical.[16] Complex spiritual assessment is also facilitated by the approach's use of self and theological reflexibilities of spiritual caregivers, helping them understand how their own and their care receivers' lived and intentional understanding of sacredness manifests in both positive and negative life situations.[17]

Secondly, Doehring's model emphasizes the importance of conducting social analysis and its relevance in providing effective pastoral care. Doehring illustrates how perpetuating social structural influences like racism, sexism, and classism influence an individual's lived theologies, significantly benefitting/deteriorating their well-being.[18] In my dissertation, I delve into another sociocultural phenomenon that has received less attention than these issues: sanism. To fully comprehend the complex nature of oppression and marginalization experienced by

[16] Doehring, *The Practice of Pastoral Care*, 187-8; 192.
[17] Doehring, *The Practice of Pastoral Care*, 89-91.
[18] Doehring, *The Practice of Pastoral Care*, 161-64.

people with lived experiences of mental distress, it is essential to investigate and address the influence of sanist ideas within theology and public discourse of schizophrenia in South Korea.

Thirdly, Doehring's model acknowledges the interconnectedness between religious or spiritual beliefs, values, virtues, embodied emotions, and linked practices.[19] This knowledge equips caregivers to deconstruct and dissect the lived theology and relevant habits and religious/spiritual practices that people with mental distress consciously and unconsciously build and uphold. This theological deconstruction can open up new possibilities, moving beyond limited perspectives within the theology of schizophrenia as a mental disability previously offered by traditional and existing theologies of mental illness in the church. A creative and critical pastoral theology, grounded in the experiential knowledge of individuals with lived experiences of schizophrenia, can provide a more context-informed, genuine, and empowering--thus, life-giving--theology of living with and caring for schizophrenia.

Fourthly, Doehring's model presents trauma-informed, liberative, spiritually integrative ways to address intense, embodied, traumatic emotions linked to embedded religious/spiritual beliefs for both caregivers and care seekers. The care model is aware of how lived theology is summoned by emotionally triggering, fear-provoking adverse events, which arouse enmeshed affective and bodily reactions activated and amplified by fragmented, rigid theological beliefs.[20] Doehring encourages a compassionate attitude by highlighting the significance of spiritual practice that engages with embodied, emotional reactions. This approach helps individuals empathize with the suffering and struggles of both those experiencing mental distress and the caregivers themselves. They often grapple with negative emotions arising from crises and their associated threats, which can exacerbate judgmental and shame-driven ideas, such as shame and

[19] Doehring, *The Practice of Pastoral Care*, 9-12.
[20] Doehring, *The Practice of Pastoral Care*, 17-18.

fear. In the context of this dissertation, these sufferings encompass distress resulting from mental illness in one's personal life, as well as the unjust treatments and discrimination endured under derogatory and alienating labels like "the mentally ill." Such experiences can lead to feelings of shame and fear.

Finally, the intercultural spiritual care model maintains a strong orientation toward social justice, recognizing its integral role in providing holistic care to individuals living in and inadvertently affected by societal harms and injustices.[21] Doehring clarified that her intention for the approach is to achieve "spiritual integration and relational justice that go beyond individual goals of healing and health."[22] Doehring argues that, instead of being separated between spiritual and secular life, the co-creating process of life-giving theology for both spiritual caregivers and care receivers extends into their daily lives, ultimately leading to the advancement of justice not only within their own lives but also in the lives of others and their communities.[23]

In the dissertation, I employ Doehring's intercultural approach in both my research processes and the care model's revision. Various advantages of the intercultural spiritual care model enable the adoption of the model for renovating spiritual care for individuals whose experiences are labeled as schizophrenia. Through intercultural spiritual care, we can recognize the commonalities and differences that exist among individuals diagnosed with schizophrenia and the broader group encompassed by this diagnosis. Lartey's intercultural paradigm explains that every human being shares universal similarities while also possessing differences that arise from their cultural communities and their individual distinctiveness.[24] This perspective counters

[21] Kathryn L. Barrs and Carrie Doehring, "An Intercultural Approach to Spiritually Oriented Psychotherapy of Military Moral Injury.," in *Spiritual Diversity in Psychotherapy: Engaging the Sacred in Clinical Practice.* (Washington, DC: American Psychological Association, 2022), 316.

[22] Doehring, *The Practice of Pastoral Care*, 6.

[23] Doehring, *The Practice of Pastoral Care*, 134-35.

[24] Emmanuel Yartekwei Lartey, *In Living Color: An Intercultural Approach to Pastoral Care and Counseling*, 2nd ed (London: Jessica Kingsley, 2003), 34-36.

the phenomenon of essentialization that individuals diagnosed with mental illness are often subjected to.

The term "essentialization" refers to the phenomenon in which descriptions and understandings of the lives of people with psychiatric diagnoses are simplified or reduced to psychiatric descriptions of their specific experiences referred to as symptoms.[25] One of the many risks and harms associated with essentialization, especially for individuals given psychiatric diagnoses like schizophrenia, is the invalidation and misrepresentation of their lived experiences, ultimately leading to their dehumanization.[26] Essentialization, within the context of psychiatric diagnoses like schizophrenia, tends to overlook the idiosyncrasies and variations that influence and exist within an individual's unique context and lived experiences, even when they share specific symptoms as described by psychiatry. This disregard also extends to the theologies of living with schizophrenia. To attain a holistic understanding of their lived experiences and theologies, one must carefully consider the formative factors, including familial and interpersonal relationships, socioeconomic and cultural backgrounds, and experiences before and after acute crisis moments and their journeys through the recovery phases. The intercultural approach, being a narrative-oriented model, recognizes and values the uniqueness of each person's story, particularly their narrative of living with mental distress and their theology.

Not only as a goal to be sought by the newly devised spiritual care model for helping reconstruct the theologies of those with lived experiences but this orientation of the method is also incorporated into the process of guiding caregivers to recognize their idiosyncratic influences on the formation of their embedded and intentional theologies. Specifically, existing sanist theological beliefs, values, and practices that care receivers have acquired from Korean

[25] LeFrançois, Menzies, and Reaume, "Glossary of Terms," 336.
[26] Liegghio, "A Denial of Being," 124.

society and the church needs to be scrutinized to dismantle them, along with other forms of discrimination, and replace them with alternative theological beliefs, values, and practices.

Considering my biases as a researcher and a family member of someone living with schizophrenia, I am not exempt from this scrutiny. Similar to my research participants, my understanding and theology of schizophrenia have been shaped by living in a sanist society rife with bias against those living with mental illness diagnoses. Practicing self-reflexivity, I have maintained awareness of the nature and impact of sanism at various levels throughout the research process, including when I have discussed this topic with my research interviewees and analyzed the data. More information on my self- and theological reflexivity, particularly regarding my researcher's reflexivity and how it influences my research process, will be provided soon in this chapter.

During the interview process, I remained mindful of the intercultural approach's emphasis on the significance of compassion. This awareness was particularly crucial when addressing the participants' and my own experiences of shame, fear, and other negative emotions related to someone's lived experience with schizophrenia. Furthermore, negative emotions are triggered by our limited competency and knowledge related to pastoral tasks, influenced by our respective embedded theologies.

Shame is one kind of reactionary response incited by feelings of inadequacy and inferiority. Shame is an emotion that develops in response to the living stigma, which results from prejudicial and stereotypical beliefs shared within society and how individuals are treated based on these beliefs regarding their identity or group membership.[27] The shame generated by the stigma surrounding mental illness extends to the families of those living with a psychiatric

[27] Patrick W. Corrigan, *The Stigma Effect: Unintended Consequences of Mental Health Campaigns* (New York: Columbia University Press, 2018), 48-49.

diagnosis, as societal sanist and ableist views are applied to them, too, although differently compared to how they are applied to individuals with the diagnosis.[28] On the other hand, fear is a common emotion experienced by caregivers when they witness the distress and struggles of someone with schizophrenia. Additionally, the fear is fueled by the misleading and harmful influences of debilitating, prejudicial societal images associated with this specific mental illness diagnosis.[29] In the construction of the caregiving model, the intercultural approach plays a crucial role in integrating the aspect of responding rather than reacting to negative emotions that may arise from interactions with individuals with schizophrenia who visit the church.

The intercultural spiritual care approach provides the newly proposed model as the framework for planning and delivering spiritual care to individuals with schizophrenia in faith communities. In *The Practice of Pastoral Care*, Doehring illustrates the three phases of intercultural spiritual care for individuals wrestling with past and current losses, crises, and acute or post-traumatic experiences. The three phases proposed by Doehring's approach are developed based on the trauma theories of Judith Herman and Marie Fortune.[30] Doehring names the three steps as 1) "Fostering compassion and trust, establishing safety;" 2) "Mourning losses and holding people accountable;" and 3) "Reconnecting with the goodness of life."[31] Each phase aims to decrease the factors/habits/actions in life that underserve the individual's purpose, meanings, values, and well-being and increase the chances and engagement with value-oriented, fulfilling, empowering life choices/decisions, under the mutual influence among one's

[28] Tally Moses, "Stigma and Family," in *The Stigma of Disease and Disability: Understanding Causes and Overcoming Injustices*, ed. Patrick W. Corrigan (Washington, DC: American Psychological Association, 2014), 247-48; 253-54; Keunwoo Park and Mikyung Seo, "Care Burden of Parents of Adult Children with Mental Illness: The Role of Associative Stigma," *Comprehensive Psychiatry* 70 (October 2016): 159–64, https://doi.org/10.1016/j.comppsych.2016.07.010.

[29] Olson and Marshall, "Psychotic Disorders," 67.

[30] Doehring, *The Practice of Pastoral Care*, 173.

[31] Doehring, *The Practice of Pastoral Care*, 174.

theological/spiritual beliefs and values. In Chapter 6, the revision of each step is presented, with consideration given to the specific needs, challenges, and goals within the specialized spiritual care context. In Phase 1, the focus is on affirming lived experiences of schizophrenia and their meanings and values while ensuring the safety of those involved in spiritual care. Phase 2 addresses the issues of grief stemming from various losses related to living with schizophrenia and emphasizes the cultivation of accountability among individuals. Phase 3 is centered on promoting and advocating for the thriving and increased wellness of individuals with lived experiences in both their spiritual and secular realms.

As an ultimate goal, the proposed model based on the intercultural spiritual care approach should lead care receivers to deconstruct and reconstruct their theology of suffering, healing, and recovery, and ultimately, intentional theology of living with mental disability in the specific context premised in this dissertation, schizophrenia. Two tasks need to be tackled to comprehend and analyze the theologies related to their lived experiences. First, their lived experiences should be interrogated and reconsidered to create a genuine understanding and empowering meanings and values more aligned with the reality of people's experiences. Second, theological illustrations and exegeses on human experiences of mental distress and people who live with it, which were previously built upon experts' languages, will need to be re-scrutinized and rebuilt, borrowing every day and theological languages of those who live with mental distress.

Dialectical Behavior Therapy

The primary reason for drawing on Dialectical Behavior Therapy (DBT) for its methodological use is to utilize the model's core principle: dialectics. Referred to as one of the theoretical underpinnings of the DBT approach, dialectics represent the philosophical, therapeutic ground that undergirds its treatment strategies, which is how the DBT views the

nature of reality as well as how it is incorporated into the treatment approach of mental illness.[32] In the dialectic view, DBT focuses on the interrelatedness of life and encourages us to consider each part of an entire system concerning other parts and the whole.[33] That means creating change in an individual's identified behaviors requires the awareness of how it relates to the person's other behaviors and his/her environments in the current context. This philosophical assumption leads to carefully examining individual distinctiveness along with his/her contextual particularities, such as gender and social class, in the assessment and treatment of the patient's mental illness.[34]

Moreover, dialectics supposes there are always polarities in life's reality. Linehan asserts, "a very important dialectical idea is that all propositions contain within them their own oppositions."[35] This principle even applies to what is considered as truth, and DBT challenges the absoluteness of truth by pointing out that "reality is not static;" it is "comprised of internal opposing forces," thesis and antithesis,[36] and their clash is engendering an unavoidable rupture to the status quo. Upon the assumption of the changing nature of reality, DBT uses a synthetic approach to facilitate changes out of the integration between the thesis (acceptance of stability) and antithesis (striving for change) regarding the patient's issues.[37] Dialectics affirm the validity on both sides, thus leading to a new temporary stability for the patient's current moment.

DBT assumes that this dialectical change does not mean it leads patients to a certain point of permanent stable condition; rather, it helps them to balance between polarities in their condition and environment continuously, understanding that "Truth is neither absolute nor

[32] Linehan, *Cognitive-Behavioral Treatment*, 30-31.
[33] Linehan, *Cognitive-Behavioral Treatment*, 31-32.
[34] Linehan, *Cognitive-Behavioral Treatment*, 31.
[35] Linehan, *Cognitive-Behavioral Treatment*, 32.
[36] Linehan, *Cognitive-Behavioral Treatment*, 32.
[37] Linehan, *Cognitive-Behavioral Treatment*, 33-34.

relative, but rather evolves and is constructed over time."[38] In terms of its clinical implications, the principle of dialectics guides clients to adopt a flexible and balanced attitude, enabling them to tolerate better distress arising from the ambiguities and pervasiveness of the debilitating issues in their lives while simultaneously encouraging them to pursue changes that will ultimately benefit them in the long term. This modality validates the usefulness of their current strategies, at least to the degree that it enables them to be emotionally stable unless it seriously damages or risks their safety and severely decreases their wellness.[39]

Reviewing dialectics as the philosophical foundation of DBT inevitably requires acknowledging its religious influence, particularly due to its founder, Linehan, who has maintained a lifelong, profound interest in religiosity and spirituality. Initially drawn to dialectics through exposure to Marxist philosophy, Linehan's spiritual exploration of the principle has been deepened and culminated in through her mastery of Zen meditation.[40] This practice enhances her understanding of genuine, radical acceptance and mindfulness, contributing to her personal spiritual transformation, which, in turn, informs the development and advancement of DBT skills, such as "Wise Mind."[41]

The association of DBT with Buddhist disciplines may pose a challenge for utilizing this in pastoral care for conservative Korean Christian groups. With a focus on examining spiritual care dilemmas, the application of dialectics in this doctoral research may extend beyond the clinical realm to incorporate a spiritual dimension. Simultaneously, the non-religious approach DBT adopts in its clinical application can reduce resistance from individuals of different

[38] Linehan, *Cognitive-Behavioral Treatment*, 201.
[39] Marsha Linehan, *DBT Skills Training Manual*, 2nd ed. (New York: The Guilford Press, 2015), 9.
[40] Marsha Linehan, *Building a Life Worth Living: A Memoir* (New York: Random House, 2020), 226-46; 273-76.
[41] Linehan, *Building a Life Worth Living*, 280-88.

religious groups than Buddhists.[42] Furthermore, the long-established East Asian philosophical tradition of dialectical thinking may offer an additional perspective for educating individuals from Confucian cultural backgrounds, such as Koreans, without relying on explicit religious references.[43]

Regarding recognizing the nature of a dilemma, the dialectical approach poses excellent potential for developing and providing a contextualized and holistic spiritual care model for persons with schizophrenia in the church. Dialectical thinking presumes that every dilemma has its poles represented by values each decision signifies. Dilemmas arise from a conflict of choices where different significant values are behind each other, which frequently leads to an impasse or halt of further investigation. Narratives of pastors indicate the difficulties in embracing the person with schizophrenia in the church, although they also acknowledge the person's needs and the imperative for welcoming and caring for the population experiencing distress and marginalization in society. The dilemmatic experiences occur within different relations, contexts, challenges, expectations, opportunities, and prospects. What has been easily missed by the pastors in navigating their dilemmatic moments is the chance to conduct synthetic thinking by thoroughly interrogating and pondering both values. In most cases, the decision previously made and the values upheld (thesis)— the decision not to include the person showing psychosis to the congregation—was quickly favored and chosen over the decision not taken and their espoused values (antithesis), without deliberately scrutinizing the available options and weighing values.

Therefore, the principle of dialectical thinking provides a comprehensive philosophical ground and, at the same time, an effective, practical approach for pastors to navigate various

[42] Linehan, *Building a Life Worth Living*, 277-79.

[43] Nikolay Veraksa, Michael Basseches, and Angela Brandão, "Dialectical Thinking: A Proposed Foundation for a Post-Modern Psychology," *Frontiers in Psychology* 13 (June 13, 2022): 710815, https://doi.org/10.3389/fpsyg.2022.710815.

dilemmas in their pastoral encounters with individuals with schizophrenia. Constructed by unique dynamics, contexts, needs, and challenges posed by all the parties involved and the situation itself, the dilemmas in different natures require an approach to walk spiritual caregivers through the navigating process of providing spiritual care. Significantly, when divergent, contradicting choices and virtues/values are seemingly uncompromisable, interests and power issues are intertwined among the stakeholders, and contextual specificities are identified, the approach to seeking the middle can be helpful. That being said, it is worth being reminded that the effectiveness of spiritual care demands more than just the skilled discretion and judgment of a caregiver. The significance of resources and community and their roles, mainly as prerequisites for practical, holistic, sustainable spiritual care, will be further discussed in Chapter 6.

In *Cognitive-Behavioral Treatment of Borderline Personality Disorder*, Linehan argues that dialectics should be applied to both the process and relationship that unfolds through therapy interactions between therapists and patients, involving therapists teaching the style of living by embodying and modeling it to their clients.[44] Dialectics helps to navigate the process, as it helps to see the poles, values, and how to "walk the middle path" instead of feeling stuck and limited to the opposing choices.[45] That means adopting the approach in the dissertation implies dialectical thinking will serve as both the method to be utilized by caretakers and taught to caregivers and the expected outcome for caregiving and care receivers.

Dialectics can be applied to various levels in this dissertation. First, by applying dialectical thinking to the interpretation and analysis of the interview data and proposing the new care model, I intend to provide an example for spiritual caregivers as my audience, guiding them on how to analyze and navigate dilemmas when interacting with individuals with schizophrenia.

[44] Linehan, *Cognitive-Behavioral Treatment*, 201.
[45] Linehan, *DBT Skills Training Manual*, 157-58.

This involves addressing challenging and dilemmatic spiritual care situations to propose a synthesized decision-making process to overcome dichotomous thinking during dilemmas and resolve consequent impasses or conflicts between values. This approach is essential for fostering a holistic care decision-making process.

The approach can also be applied in providing spiritual guidance to people with schizophrenia, helping them adopt a more balanced and flexible approach to living their lives fully. This use aligns with what Doehring emphasizes as the life-giving aspects of intentional theology for individuals grappling with life's complex, messy, and ironic realities.[46] Both spiritual caregivers and recipients inevitably face various dilemmas in their care interactions, as Linehan suggests that the reality of life is in constant change when pursuing change.[47] Among the eight dialectical thinking strategies presented by Linehan in her book, finding "shades of gray" instead of black-and-white thinking or "Entering the paradox" between opposing opinions without suggesting a resolution can serve as practical examples.[48] The dialectical approach, as implied by terms such as "synthesis" or "middle path," involves recognizing the values and virtues inherent in options at both ends of the dilemmatic care situation. This approach enables a deliberate, context-informed, and flexible decision-making process, in contrast to decisions made based on anxiety-driven, rigid, and prejudicial beliefs. Other DBT literature offers practical exercises for applying dialectical thinking principles in therapy and daily life.[49] The common

[46] Doehring, *The Practice of Pastoral Care*, 18-19; 89-92.
[47] Linehan, *Cognitive-Behavioral Treatment*, 33-34.
[48] Linehan, *Cognitive-Behavioral Treatment*, 208-18.
[49] Tali Boritz et al., *Deliberate Practice in Dialectical Behavior Therapy*, Essentials of Deliberate Practice (Washington, DC: American Psychological Association, 2023), 131-39. Here are a few exercise sentences of "Promoting Dialectical Thinking Through Both–And Statements," from the chapter: Client: "**[Irritated]** I'm trying so hard. I don't think you understand how hard it is. Some days I just don't feel like working so hard." Therapist: "You are doing your best, and you need to try harder;" Client: "**[Sad]** I want to leave my job, but I don't want to disappoint my boss. He's been really supportive. I feel like if I leave, I'm going to let him down." Therapist: "You care about your boss, and you don't want to continue in the job."

rationale behind the recommended skills and techniques is to identify the belief and choice that are strongly favored as the most reasonable, beneficial, valuable, and true in current issues (thesis) and to question their validity. Then, present the opposite option as the antithesis, as it offers alternative perspectives that may be less explored. The ultimate goal is to construct a synthetic choice that affirms the validity and values of both options and creatively mediates between them to reach a balanced resolution.

In revising the spiritual care model for individuals with schizophrenia, it is essential to recognize that dialectics can provide valuable guidance throughout the formation and implementation process of this care model. Effective spiritual care for individuals diagnosed with schizophrenia requires addressing complex issues that intersect and intertwine the experiences of those directly and indirectly impacted by schizophrenia.

First and foremost, ensuring the safety of all involved parties, including caregivers, care receivers, and bystanders, should be a central focus integrated into the proposed model while concurrently maintaining an anti-sanist stance. Second, the model should promote "compassion" towards care receivers while simultaneously addressing the emotional reactions that caregivers may have due to their understanding, experiences, and lived theology regarding severe mental illnesses and those living with them.

Furthermore, it should be noted that the sustainability of care depends on the availability of resources, ongoing support, and the participation of groups and the entire community in the care. Simultaneously, efforts should be made to enhance the capacities, knowledge, and attitudes of individuals serving as spiritual caregivers. Lastly, it is crucial to consider the limitations and challenges within the current mental health system in Korean society. The model grounded in dialectical thinking does not aim to downplay the severity, struggles, adversities, and injustices

faced by individuals, their families, and those who work with them. It also acknowledges the scarcity of resources and the realistic limits that hinder efforts to envision alternative approaches to the current treatment of people with lived experience of mental illness. Methodologically, adopting dialectics is intended to prevent the unintentional promotion and implementation of another rigid, impractical, and unsustainable spiritual care intervention.

Research Design

Planning

In my original research design, I planned to investigate and uncover two elements of Korean pastors' experiences in caring for individuals with schizophrenia: 1) the undiscovered positive and 2) relational moments during their pastoral care encounters with persons with schizophrenia in the church. These foci were centered on designing research, conducting semi-structured individual interviews with research partners, and analyzing data in conjunction with the two theoretical concepts: 1) Anti-sanist and mad-affirming approach to understanding schizophrenia and 2) relational mutuality embedded within care relationships. As "a form of systemic and systematic discrimination and oppression," sanism has perpetuated prejudices, unjust treatment, and invalidation against individuals whose cognitive, emotional, or behavioral experiences do not conform to society's norms for sanity.[50] To counter sanism deeply rooted in society, one of the fundamental tasks of Mad Studies is "[t]o support the development of diverse non-medicalized individual and collective survivor narratives to counter dominant-based ones."[51] To read the narratives of spiritual caregivers of schizophrenia through anti-sanist and mad-affirming approaches, I formulated two analytic questions:

[50] Vermont Psychiatric Survivors, Inc., "What is Sanism?," Facebook, May 7, 2018, https://www.facebook.com/VermontPsychiatricSurvivors/posts/pfbid05NqHvMx9Mh1f67q26HbhHAg4EHUmp6Bo9RigELHdAiRkncCEKkSb3aiGWvm9LhPSl.

[51] Beresford, "'Mad', Mad Studies and Advancing Inclusive Resistance," 1341.

1) How is sanism embedded in the religious and cultural constructs of schizophrenia and leads people to feel and act in interacting with people identified with the diagnosis?

2) What are the moments caregivers intentionally or unintentionally discover and appreciate non-pathologizing, mad-affirming, and humanitarian views of their care receivers' lived experiences of schizophrenia and how they influence them?

I also borrowed the feminist epistemological and theoretical perspective of relational capacity and mutuality that particularly challenge the traditional philosophical notions of human agency, capacity, and care for human dependency to reconstruct the theological view on caring for people with heavy dependence accompanied by the experiences of schizophrenia. In reevaluating the agency and capacities of people with schizophrenia to reciprocate and influence their caregivers, as well as reexamining the positive outcomes the relationship offers to both parties, I formulated the following analytic questions:

1) What do caregivers experience from their care receivers showing their relational and affective capacities to positively interact/reciprocate/benefit from/care for them, and how does it change their perspectives on people with schizophrenia and their lived experiences?

2) When and how is the caring relationship positively experienced and acknowledged by the caregivers in a way that they both feel benefited?

After the first two individual interviews with research participants based on the research questions formulated above, I encountered unexpected outcomes, which yielded more limited and pessimistic results than my hypothesis had suggested. I previously assumed that those positive and relational experiences are inherent in the pastors' experiences but only overshadowed by caregiving burdens and challenges. Thus, the findings led me to contemplate the reasons behind them. While recounting their experiences with individuals identified as having schizophrenia, those interviewees could not recall any significant, positive moments during their interactions with these individuals. They also could not report any positive impressions or evaluations of either the person or the interaction, as they denied learning any

meaningful or valuable knowledge or lessons from which they could have benefited in the future. They assessed the roles of pastoral care as marginal and limited in the context of caring for individuals with schizophrenia in the church, recognizing that more care should be assigned to mental health/psychiatric professionals outside the church.

What I observed from the first two interview results were distinct patterns of dilemmas that the interviewees both explicitly and implicitly described. The interviewees reported a sense of incompetence and uncertainty in their roles, tasks, and boundaries, as well as conflicts between values and among people in the church they served in providing pastoral care in that specific context. These challenges arose from the various types of dilemmatic moments when providing care for individuals with schizophrenia, as well as pastoring other congregants. This learning prompted me to shift my research focus from discovering hidden positive and relational moments within pastoral care encounters with people with schizophrenia to analyzing the limited understanding and beliefs regarding the spiritual care of this population and the resulting dilemmas. I intend to study these limited views that prevent spiritual caregivers from simultaneously experiencing positive and relational interactions with those living with schizophrenia, which consequently leads to various types of dilemmas. Ultimately, I modified my research and interview questions in preparation for the upcoming interviews. While retaining sections that address positive or relational moments in relevant pastoral care experiences for future research participants, I have finalized five research questions and the interview questions presented in the interview process section below:

1) How is sanism embedded in the religious and cultural constructs of schizophrenia and how does it lead people to feel and act in interacting with people identified with the diagnosis?

2) What are the positive or relational experiences beyond pathologizing, essentializing views of schizophrenia that pastors experience during the spiritual care of people with

schizophrenia in the Korean church?

3) How do pastors' and church's theologies of schizophrenia and spiritual care for people with lived experience of it positively and negatively affect their understanding, attitude toward their pastoral care tasks and duties, and evaluation of their experiences?

4) What difficulties, limitations, and failures did the pastors experience on various levels while providing spiritual care to individuals with schizophrenia?

5) How did the pastors' upheld beliefs and values impact their decisions when providing spiritual care to a person with schizophrenia in challenging, dilemmatic situations?

6) What beliefs and values are disregarded or undervalued when deciding how to care for people with lived experience of schizophrenia, especially when they face limitations or dilemmas?

Recruitment

Not surprisingly, but longer than I expected, this stage took much more time in my research. Once my IRB (included as Appendix A) and dissertation proposal were approved, I began advertising to recruit research participants from the Korean and Korean-American Protestant pastors' pool in January 2022. I created a recruitment flier for research participants, uploaded it to my social media, and shared it among Korean clergy groups to explain the interview process and eligibility for potential participants. Only one research participant contacted me through the poster, while I had to personally contact those working as ordained ministers in different Christian denominations in Korea and the US. Before being connected to additional six potential research interviewees, I had been rejected by almost eighty pastors from inviting them to share their experiences during the interview. Most of them presented the exact reasons for their ineligibility to be an interviewee: they said they had never met people diagnosed with schizophrenia in the church. While they had parishioners diagnosed and struggling with various types of mental illnesses, they claimed that cases of schizophrenia were too rare to see in their church. Some of them even added comments such as, "People with schizophrenia are so

difficult that the church can't do anything to care for them," or "People would rather hide or stop coming to church if they were diagnosed with such an illness."

After interviewing with first three participants, I changed my participant selection strategy from random contacts to individuals who had written or published content on the topic, such as news columns, social media posts, or degree research projects. Upon my contact, additional four agreed to participate in interviews.

Throughout my recruitment process with seven participants, I adhered to the following routine. I introduced myself and my research briefly to the people I reached out to and inquired whether they would be interested in participating. Upon verbal consent to the interview, I provided them with the informed consent form (included as Appendix B). This form outlines the interview research process and their rights regarding confidentiality, along with information on requesting additional details, withdrawing from the research, and contact information. After receiving their signed forms, I contacted each interviewee to schedule a Zoom interview and sent them a video chat link. Any questions or concerns they had were addressed at the beginning and end of each interview.

Interview

Between March 2022 and June 2023, I conducted 60–90-minute semi-structured individual interviews online with seven Korean Protestant pastors who served congregations of varying sizes, ranging from 15 to approximately 500 members. During the period of their encounter with a person with lived experience of schizophrenia, six pastors were ministering to local churches, while one was assigned as a military chaplain to a church with a congregation consisting of individuals serving their compulsory military service duty and military officers. Their church sites were located in different regions of South Korea, including urban and rural

settings. The pastoral encounters with individuals diagnosed with schizophrenia occurred as early as the mid-2000s and as late as 2022 while mostly happening during the 2010s. Regarding the genders of the research participants, six pastors were male, and one pastor was female. The individuals they encountered during their pastoral work included six males and one female, with one participant serving a group of 15 males. The duration of these encounters varied, ranging from 3 months to 4 years.

After reflecting on the research questions revamped upon reviewing the results of the first two interviews and the research journals I wrote immediately after each interview, I revised and finalized the interview questions for subsequent interviews. The questions used in the interviews are as follows:

Pastoral experiences with the person

1) Can you briefly describe your pastoral experience with a person with schizophrenia? When, where, how long, what happened, when was the last time you saw the person, and where is the person now?

2) What struggles and obstacles did you experience in performing pastoral tasks for an individual with schizophrenia while serving the whole congregation?
   i) What difficulties did you experience personally?
   ii) What difficulties did you experience as a pastor?
   iii) How was the relationship between the individual and other church members, and was there any conflict between them?
   iv) What difficulties or inconveniences did the church face?

Positive, Neutral, and Negative Experiences

1) Have you had any positive experiences from encountering and interacting with the individual? (Impressions, emotions, ideas, insights, change of existing perceptions of the person or the identified group)

2) Have you had any negative experiences from encountering and interacting with the individual? (Impressions, emotions, ideas, damages, change or intensification of perceptions of the person or the identified group)

3) What have you learned from the encounter about schizophrenia and people with lived experience?

Understanding of Schizophrenia

1) How do you understand experiencing schizophrenia as a severe mental illness/mental disability? Are they the same/different from other types of illnesses or disabilities?

2) What is your theological and religious understanding of experiencing schizophrenia? Is it theologically understood differently from other illnesses/disabilities?

3) Do you think schizophrenia could be healed by faith?

4) What are the benefits/roles of faith for those with lived experience?

Demon-possession

1) What do you think about demon possession? Do you think it is related to the experience of schizophrenia or other mental illnesses?

2) Are there tasks pastors can/should do for those experiencing demon possession?

Schizophrenia in Korean Society and church

1) What are the images of an individual with a schizophrenia diagnosis? Do you agree with them?

2) What challenges and barriers do you think a person with schizophrenia would face in living in Korean society?

3) Do you think the views and treatments of the group in the Korean church are different from society? If so, how?

4) If some obstacles and barriers prevent people with schizophrenia from joining the church, what would be those?

Pastor's and the Church's Roles

1) What are the pastor's roles for the church members who live with schizophrenia?

2) What are the church's roles for them?

3) What do you think congregations would expect their pastors to do when an individual with schizophrenia comes to their church?

4) What kinds of difficulties and challenges pastors and the churches would face when individuals with schizophrenia attend the church?

5) Have you served those with other illnesses/disabilities in the church? How different were those experiences?

Evaluation of the overall experiences

1) Overall, how do you evaluate the experiences of the person with schizophrenia?
    i) What thoughts or emotions have you had in serving as caregivers for the person's experiences of schizophrenia? What have you gained or lost from providing the care?
    ii) What have you gained or lost from the encounter?
    iii) Do you think the experience would be helpful if you meet another person with schizophrenia in your future ministry?

2) Is there anything to add to or clarify your answers or other related experiences?

The interview began with the researcher explaining informed consent and the study's purpose. During interviews with seven pastors, they were asked to recount their memories of encounters with individuals with schizophrenia in the churches they served. Following the recollection of these memories, the pastors evaluated their experiences. The pastors also shared their understanding of how pastors and churches can play a role in helping individuals who came to their congregations. In most cases, these individuals were identified as having schizophrenia and visited the church. However, there was one interview about a church member who had joined the church before experiencing their first psychotic episode and continued attending.

Using Zoom video-chat software, the entire interview was recorded and stored with passwords on the researcher's laptop. After each interview, I wrote a research journal to record my impressions, evaluations, insights, and the difficulties I encountered during the interview. Each participant was later contacted via email, briefed by the researcher on a summary of their interview, and asked to identify any incorrect or mistaken details, which the interviewees then corrected and confirmed.

Coding and Analysis

I used ATLAS.ti 22 software to transcribe the recorded audio of the interviews and code the transcripts. For the initial coding cycle, I adopted the traditional way of thematic coding to categorize the Korean pastors' understanding and experiences of providing spiritual care to

individuals with schizophrenia within the church. The open thematic coding cycle produced: 1) Understanding of Schizophrenia, 2) Views on people with schizophrenia in Korean society and church, 3) Anticipated pastoral and ecclesial roles, 4) Pastoral engagement conducted, 5) Dilemmatic experiences, and 6) Evaluation of the experiences. The code Dilemmatic experiences includes seven subcodes: 1) Personal, 2) Pastoral, 3) Relational, 4) Theological, 5) Ethical, 6) Epistemic, and 7) Practical Dilemma. Ultimately, three themes emerged from the analysis of these codes: 1) Stories, 2) Expectation versus Reality, and 3) Dilemma.

For their critical analysis, pastors' narratives, centered on their experiences with seven types of dilemma and other relevant negative experiences, are re-examined reflecting on two theoretical concepts, using the analytical process of "thinking with theory." These two concepts are 1) Sanism embedded in beliefs related to living with and caring for schizophrenia, and 2) Dialectical thinking approach to address dilemmatic moments in spiritual care of people's lived experience of schizophrenia. Plugging the data into the theories of sanism and dialectics and vice versa enables critical reading of narratives, unveiling underlying ideas of injustices and oppressions regarding the group of people with schizophrenia and overlooked and unappreciated aspects of the caregiving experiences of them. Dilemmas, where pastors encounter dead-ends, lead to confusion, frustration, discouragement, and a temptation to withdraw from their caregiving efforts as they recognize assumed and anticipated limitations and too many burdens imposed on them. The results of these analyzing processes will be presented and discussed in detail in Chapter 6 and 7 respectively.

Researcher's Reflexivity

Ever since I witnessed my uncle's unusual behaviors during his acute episode of schizophrenia, I have become overly protective of anyone who looks or sounds "abnormal." As a

gut reaction, I avoid paying attention to those behaviors or individuals or immediately shutting down or withdrawing if I can. It is my way of hiding my family's secret and proving my unrelatedness to people like my uncle, fearing that I, too, could be treated as "crazy" like him. Therefore, concealing my familial connection to "the crazy people" while sharing my peculiar academic interests and work with others feels precarious. The cohabitation of my personal suffering from observing my uncle's and family's struggle with schizophrenia and my outwardly expressed academic pursuits has continued for a long time. My long-held avoidance of disclosing a direct relationship with my uncle with schizophrenia persists within Korean sociocultural and religious contexts that constantly evoke fear, guilt, and shame regarding people labeled as "schizophrenic" and anyone related to them. My embedded theology of schizophrenia has been the coexistence of a desperate search for salvation for my uncle and family and a silent neglect of God, whose healing power has not reached him and us, allowing him to relapse repeatedly.

Exposure to liberation movements like Mad Studies, Neurodiversity, and Survivor's Research has opened my eyes to the unattended territories of injustices and oppression faced by individuals with mental distress beyond the previous fixation on my uncle's cure through medicine. This encounter inevitably yields two different reactions of mine as a theologian and researcher: 1) Open and progressive to innovative, creative theoretical/theological ideas, and 2) emotionally charged, defensive visceral reactions towards others' sufferings led by someone's schizophrenia experiences. Despite the ongoing influence of these embodied emotions, I have established my intentional theology that God's salvation for those living with schizophrenia lies in building a thriving life amidst their lived experiences by fulfilling their potential alongside believers in solidarity who collaborate on their liberation and empowerment as an expression of faith.

Reflecting on my own double standards and attitudes during interviews with research participants, I recognize moments when I feigned agreement with sanist-ableist views or responded with laughter to pejorative descriptions of individuals experiencing schizophrenia, in denying my connection. This indicates the cultural and religious sanist influences that have overshadowed me throughout my formation period even until now. Acknowledging my biases and recognizing the limits as a practical theology researcher, along with my passion, I find myself oscillating between advocating for people with mental distress and denying my personal connection, driven by feelings of shame, guilt, grief, and sadness: my own research dilemma. Therefore, I have paid additional attention to maintaining my non-judgmental attitude towards my charged emotions and dilemmas while keenly acknowledging their influences on both myself and my research.

Conclusion

Reviewing the main characteristics and advantages of the methodological research approaches, as well as outlining the plan for their usage, elucidates how research data are produced and analyzed in the upcoming chapters, with specific and intentional research foci. The researcher's reflexivity regarding his personal and research dilemmas provides a glimpse into the multifaceted issues surrounding the spiritual care of individuals with schizophrenia, which will be closely examined in the subsequent chapters.

Chapter 4

Stories and Expectation Versus Reality

Introduction

During the interviews, the seven pastors were asked to recount and evaluate their memories of encountering individuals with schizophrenia at the church they served. Following this, they were asked to describe their general and theological understanding of schizophrenia and people who live with it, how these individuals are seen in Korean society and church, and how they believe pastors and churches can pastorally care for them. With the exception of one interview pertaining to the church member who later underwent his first episode of a psychotic crisis and continued attending, all cases occurred from the joining of those identified individuals, catching the pastors and congregations unprepared. Except for one instance of an individual's passing away, all of those encounters ended with the voluntary leaving of individuals from the church.

The coding of the interview data yields six categorized experiences of the research participants: 1) Understanding (Understanding Schizophrenia), 2) Viewing (Views on people with schizophrenia in Korean society and church), 3) Expecting (Anticipated pastoral and ecclesial roles, 4) Engaging (Pastoral engagement conducted), 5) Getting Stuck (Dilemmatic experiences), and 6) Evaluating (Evaluation of the experiences). These six groups have been merged into three themes regarding the participants' experience of spiritual care of people with schizophrenia in the Korean church context: 1) Stories, 2) Expectation versus Reality, and 3) Dilemmas. This chapter presents "Stories" and "Expectation versus Reality," while "Dilemmas" will be introduced in the next chapter. The Stories section provides the narratives reconstructed

by pastors, with their evaluations. Expectation versus Reality covers the pastors' view of those with lived experiences of schizophrenia and their perception of the views held by Korean society and churches, what they believe the pastoral and ecclesial duties are in providing pastoral care, and what they believe they themselves and the church they serve actually can do to help. This is presented with a focus on the consonance and dissonance among the perceptions, beliefs, and experiences of spiritual care encounters of the research participants, as they intersect and mutually influence each other.

Stories

The narratives of the Korean pastors are grouped into three types, based on how they are involved in the pastoral care interactions with each individual identified with schizophrenia: Neglect through Distance (HL, SH), Struggling to Care, Alone (TR, HC), and Persevering for Embrace, Together (JH, KJ, WJ).

Neglect through Distance (HL, SH)

The interviewees in the first group had limited interactions with individuals identified as experiencing schizophrenia in their church. While neglect through distance sometimes overtly occurred, it was also shown in a subtle, covert way of not fully embracing those with schizophrenia into the faith community on various levels. The categorization of these stories as neglect does not imply that it is a consequence of a deliberate intention to ignore or alienate the individual by either the interviewees or the congregations in the respective faith communities. Rather, it reflects a reality influenced by the lack of conscious efforts to actively embrace and care for these individuals and various additional factors that impede the pastors' and churches' ability to provide care. For example, faith leaders' and congregations' lack of knowledge or feelings of incompetence and powerlessness when engaging with a person with severe mental

illness leads to a “conspiracy of silence,” in which they passive-aggressively push people away from their community after failing to accept them. The stories of two pastors, HL and SH, are narrated differently but share the pattern of not acknowledging the full membership of the individual with schizophrenia they interacted with. This is displayed through the pastors’ and church’s attitudes towards the individuals, which inevitably led to the marginalization of the person and their voluntary departure.

HL’s Narrative

HL is a male Korean ordained Methodist pastor. During the 2010s, he had an encounter with a Korean male in his 30s over a six-month period in the young adult group (which ranged from 200 to 250 members) at the church where he worked as an assistant pastoral director. This individual openly disclosed his schizophrenia diagnosis within the church newcomer group during his three months with the group. He allegedly exhibited unusual behaviors, including making threatening remarks, excessively contacting other members, and appearing to carry a knife-like weapon, although he never used it. After three months, when newcomers typically join small groups with regular attendees, the pastoral leadership decided not to assign him to any small group. This decision was based on their pastoral assessment that he did not fit into their faith community.

In the subsequent three months, the individual persistently sent text messages and made countless phone calls to the pastoral leadership, day and night, even using numbers with blocked caller IDs. Allegedly, he also impersonated HL and sent defamatory text messages to lay members of the community, causing significant trouble and confusion in the community. Pastoral leadership decided not to respond to the individual and advised all group members to ignore the person’s attempts to make contact. As a result of being avoided by pastors and church

members, without objection from anyone in the group, the individual voluntarily left the church. Several months after the individual left, HL received a call from another church inquiring about an individual that was causing similar issues in their community. Shortly after HL shared the details of what happened at his church, the person returned and caused a brief disturbance, but never returned.

Recalling these events during the interview, HL evaluated most of his experiences as being negative. While he states the experience with the church member did not incur any negative lingering emotions or impacts in him currently, HL denied the possibility of a positive interpretation of the experience for himself and others in the community:

> **Minhwan:** So, you mentioned since there were a bunch of behaviors [from the individual] that were kind of ongoing, aggressive, and very stressful for everyone, thus there is no room for the experience with him to be interpreted or remembered in a positive way by the pastors or lay members of the community at that time?
>
> **HL:** Not at all. I don't think any of us on the pastoral team, and I don't believe any of the members in the community at that time, felt bad for him. He wasn't even asked to leave the community due to his behaviors, but he chose to leave anyway. I don't think anyone felt sorry for him or regretted his departure. Moreover, no one blamed the pastoral team for the decision not to assign him to a small group or how the issue was handled. There was a clear consensus that it was the right thing to do at the time, among the pastoral and lay leadership, as well as the small group leaders.

Furthermore, HL strongly refuted that there was anything in these experiences that could help him grow personally or professionally. The negative emotions experienced by the pastors, other church members, and the entire community due to the individual's behaviors were apparently so

intense that they formed an exclusively negative impression of the person and the events related to him. HL concluded that the encounters did not help him imagine how to better prepare and be equipped for future pastoral encounters with another individual diagnosed with schizophrenia in the church. Despite HL's negative interpretation of his experiences, while admitting that he got an impression that individuals with schizophrenia are more difficult to deal with than those with other illnesses/disabilities, HL subtly expresses his regret for not actively trying more to help the individual instead of inevitably neglecting him.

SH's Narrative

The case of SH illustrates how the pattern of distancing and shunning a person with schizophrenia within the church can unfold in more nuanced and subtle ways. SH is a Korean Methodist pastor who currently serves as an associate pastor at a church in Korea with 500-600 regular attendees. Around 2020, SH observed a male lay member in his 50s for two years. Allegedly, the member experienced his first episode of schizophrenia during his study abroad in his 20's. Returning to Korea, he attended the church again until he voluntarily left.

SH shared his impressions of the person, describing him as awkward and shy, with a tendency to stammer. Aside from these visible characteristics, while the member was presumably on medication, SH could not discern any noticeable differences between him and people without schizophrenia. Even the member's behavior during worship, which initially caught SH's attention—standing, moving back and forth in the sanctuary, and wandering around—was not viewed as symptoms of schizophrenia. Instead, SH interpreted these actions as Holy Spirit-driven behaviors, akin to speaking in tongues, which are considered acceptable in the Korean Church. The member's peers, who had known him since childhood, understood his behaviors but did not engage closely or seek deep relationships with him.

At some point, the church member stopped coming to worship services. SH assumed the member's condition had worsened, starkly contrasting with his previous enthusiastic participation in various services throughout the week, even during the early stages of the Covid-19 outbreak when any in-person gathering was strictly limited. The person also avoided calls from the church, leading SH to presume that he did not want to display his symptomatic behaviors to others. Later, after the individual resumed attending services at one point; however, at the end of year, he learned that he was not selected for the position of "deacon," a lay leadership role—one that those who have attended and provided service to one church for a good amount of time could expect in the Korean church context, and one that he sincerely yearned for. Disappointed with the church's decision, the member accused them of viewing him as abnormal and discriminating against him because of his mental illness. Subsequently, he left the church for another one.

The alienation of the individual in this case had taken place gradually and covertly; his attendance at the church was neither prohibited nor was his membership outwardly denied. Moreover, he maintained superficial relationships with peers who had known him for a long time. SH suggests that in larger churches like his, each individual is less visible, which is why the member did not face blatant rejection or discrimination from those without any ties to him. Nevertheless, as the individual resisted the invisible discrimination against him, the unspoken rule in the church surfaced from beneath, ultimately resulting in his departure:

> **SH:** Well, first of all, I think there's an idea of the church's ideal lay leaders, and he just didn't fit into that. No one thought it was weird that he wasn't selected, other than himself and his mother. I wouldn't outright say that it was because he was schizophrenic,

but I think it influenced the [church's] decision. It definitely had an effect, and I... yeah, it affected [the choice].

Minhwan: As you mentioned before, even if he met the church's standards for being chosen, such as offering tithing regularly and fully attending services?

SH: That's a good point. Even if he did, it probably wouldn't have gone down as he wanted… This is a really interesting [discovery]. Because this is a very sensitive topic, but it's very important too. In the entire Korean church, I don't think there is a single church that would appoint a person with schizophrenia to be a deacon [lay leadership title in the Korean church]. I just don't see it happening.

While the decision not to appoint the member as a deacon was that of the church, not SH's, and it is only SH's hypothesis that the person would still be considered unqualified even if he had met the conditions, the story evolving around the decision carries diverse meanings on various levels, extending beyond one pastor's personal and his congregation's views. This will be further discussed in Chapter 5.

SH evaluated his encounter less negatively since the individual did not cause disruption or conflict during his worship attendance, except for the time he fiercely complained about the church's decision. SH retained a positive impression of the individual for his devoted faith, particularly regarding his strong desire to be cured and for his troubles to be resolved. Additionally, SH considered his experiences with the member to be helpful to his future ministry, giving him insight into people with diverse personalities and characters. Paradoxically, those expectations belie his lack of clarity in understanding pastoral care available for the population with schizophrenia.

Struggling to Care, Alone (TR, HC)

The second pattern of pastoral encounters describes cases where pastors were deeply involved and committed to the care of individuals with schizophrenia, without receiving sufficient support or endorsement from congregations. One major difference from this group to the last group is the lack of interaction between the individual(s) with schizophrenia and other congregants, as if these individuals are invisible to the congregation except for the pastors.

TR's Narrative

TR is a male Korean Presbyterian pastor in his 70s, who served as the associate pastor assigned for a group of 15 adult men diagnosed with various psychiatric conditions, with the majority diagnosed with schizophrenia. These individuals had previously been incarcerated in a forensic psychiatric hospital for their crimes but were now residing in a transitional recovery program as part of their social rehabilitation after their release.

The pastor became connected with this group shortly after serving the church as an associate pastor. Initially, other churches had rejected the group's request to attend Sunday worship services due to their history of crime and incarceration at a psychiatric hospital. Since the research participant himself had personal experience with a family member living with schizophrenia and had a keen interest in theological education related to the church's role in the care of people with schizophrenia, TR persuaded the senior pastor to welcome the group to their church. TR assumed a pastoral responsibility for attending worship with the group, leading small group discussions, and providing individual pastoral counseling. TR reported that the group had attended the church for almost five years before deciding to join another church which specialized in ministry for people with mental/psychiatric illnesses.

Throughout their time at the church, the group had little to no interaction with other congregants. TR was disappointed that both the senior pastor and other church members displayed indifference and guardedness toward the group, evident in the limited financial and other support and the absence of interaction. Furthermore, TR mentioned that some congregation members had complained about disturbances caused by the unusual behaviors of specific group members, such as showing an interest in a female church member, requesting to borrow money, or showing up at the church during the night. Thankfully, TR said these issues did not escalate into serious problems.

Throughout the interview with TR, I could not help but reconfirm his passion and calling to care for people living with mental illnesses. Along with TR's family experience, he is firmly convinced that the Church's essential mission is to serve people with mental illness as the "little ones" in society (Mt 18:6, NRSV), a reference he consistently made during the interview. His deep religious commitment ironically clashed harshly with the lack of interest and support from his congregation:

> **TR:** I have experienced great joy and gratitude witnessing the depth of understanding and relationship building [with people with mental illnesses from the group], leading to a process of their genuine recovery rooted in such understanding. Ironically, I find myself perplexed and frustrated because the potential for recovery is so evident; despite this, they still lack awareness and insight, leaving them feeling confused and lost.
>
> **Minhwan:** Who are they feeling confused and lost?
>
> **TR:** Everyone [people with schizophrenia, families, church, etc.]! Especially the family members. Because they don't know, they just put up walls and disconnect [from the individuals with schizophrenia]. Of course, families are people who have a tremendous

> amount of trauma, whether it's their house burned down or their family members being murdered or something like that. They've abandoned their family members [with schizophrenia], and now they're carrying that tremendous trauma with themselves. Who could heal them? Medical treatment is for patients, but the other wounded family members, the whole society, and the church, etc., who are facing these walls, don't grasp how happy and grateful they would become if they recovered [from their own wounds and struggles]. It would be so good if we could all be together, but due to ignorance and indifference, I think that's why we can't resolve this problem.

TR's convictions are evident in his evaluation of his experiences with the group. He assessed these entirely positively, attributing the unusual behaviors, attitudes, and sequential disturbance/confusion of group members to their illness while minimizing their significance or negative impact on him. What stands out clearly in TR's answers is his frustration with the clergy's and the church's apathy and unwillingness to minister to this group. TR sees the former as being responsible for the fear, confusion, and distance felt within the latter. His struggle to bridge the gap between people with mental illnesses and those without in the church reminded him of the vast disparity between the ideal (the *theory* of practical theology) and reality (the *practice* of practical theology).

HC's Narrative

HC, a Korean male Methodist pastor in his 60s, recently experienced the passing of a male church member of a similar age who lived with schizophrenia. HC had known him for 15 years as a church member, including 10 years of living together at the church. They began living together when the person was hospitalized during a schizophrenic relapse. HC chose to provide a

private space at the church next to his parsonage, enabling him to take care of the individual, despite objections from HC's family.

HC recalled that he was the only one who actively interacted with the individual in the small church he ministered; the individual also tried to stay away from others. He added that the church member had low motivation and overall low daily functioning levels, which are what initially prompted HC to decide to live with them. While avolition, low functioning levels, and an excessive smoking habit were challenges HC struggled with, he explained that he built a good rapport with the individual. They followed the pastor's suggestions very well, unlike those of other people or professionals. The pastor managed all the individual's living arrangements, including medical checkups, medication management, and social welfare assistance. The individual's major church activities were attending worship and Bible studies.

The interview with HC did not articulate his theological arguments for pastoral care regarding people with lived experience of schizophrenia, unlike TR. However, his account of living with and caring for a church member with schizophrenia clearly demonstrates his sacrificial efforts to serve the best interests of the individual, who his own family had abandoned. HC is one of the few participants who are well-versed in psychiatric knowledge about schizophrenia and how to support individuals diagnosed with it, linking with medical and social support resources. He gained this knowledge through his own research and interactions with the individual's psychiatrist and other professionals. HC's choice to be present and involved in the individual's everyday life required sacrifice on his part and his family's.

Much of HC's evaluation of the interaction is positive, reflecting his well-established trust, relationship, and affection for the member. However, HC also reports his dejection regarding the individual's slow recovery process, which manifested in a lack of motivation and

effort to care for themselves. HC's description of the ambivalence he witnessed at the individual's funeral is telling of the way individuals with schizophrenia are perceived in Korean society. Being in stark contrast to his sorrow and regret, HC found the reaction of the individual's family troubling: "As I led the funeral, I realized it wasn't a 'happy ending' for me, but the family was all 'happy' [that it was over]."

Additionally, what troubled him most throughout his time of providing care to the individual was other pastors' apathetic and indifferent criticism of his choice. Out of both concern and reproach, other pastors neither supported nor encouraged HC's decision to care for a non-family member in the church, one whose medical issue is something many people would never attempt to understand:

> **HC:** [sighs] I've heard all kinds of things, like accusations and concerns about why I would have a mentally ill person living in the church, from pastor colleagues—too many of them. They simply don't get it. They just don't try to understand, both church and pastors. Though I don't know the exact cause of why schizophrenia takes place in people, isn't it just a matter of individuals with mental illness falling outside the range of what's considered normal? If you fall short of being normal, you are mentally retarded. When you exceed the limit of being normal, that's schizophrenia. That's a state of too much. That's it. But they [pastors and churches] simply don't see it and lack understanding. Maybe when your own child has it[schizophrenia], you may understand it, but otherwise, you just simply don't want to know.

Both the cases of TR and HC highlight structural and systemic limitations imposed on pastors as individuals, even when they possess knowledge, experience, and passion for caring for a person

with schizophrenia in the church, thus impeding their ability to effectively provide spiritual care and increasing the chance of burnout.

Persevering for Embrace, Together (KJ, JH, WJ)

Lastly, three research participants are grouped based on their experience of a community that positively responded to their efforts in caring pastoral interactions with an individual experiencing schizophrenia. Although their experiences were not immune to struggle, conflict, confusion, disturbance, discomfort, complaint, or strife, the pastors' and congregations' orientation to embrace the person with schizophrenia as much as they could remain throughout the course of their encounters. Furthermore, this mutual commitment unfortunately did not guarantee the person's stay in the community, as none of the individuals remained in the church, due to various causes and contexts. However, it is worth noting that in these three cases, individuals' sense of being accepted and the community's commitment, out of their faith, to the individuals even after identifying their schizophrenia, were stated—although I do not hastily conclude yet a direct causal relationship between these two.

KJ's Narrative

KJ is a Korean male pastor in one of the Presbyterian denominations in Korea, currently in his 50s. He encountered a female in her 60s exhibiting behaviors identified with schizophrenia when she started attending the church he served. During her initial attendance, the individual loudly and repeatedly commented on the sermon and other worship activities, becoming aggressive, though not physically violent, when people attempted to intervene. After two weeks of her attendance at Sunday worship services, the church's steering committee convened and decided not to prevent her from attending services. Subsequently, the individual attended other

worship and prayer services on weekdays every week for the next three months, consistently displaying the same behaviors.

KJ was the one who interacted most with the individual. He noted that the degree of disturbance caused by her behaviors fluctuated, and in severe cases, it interfered entirely with the service. He assessed that her attendance did not significantly impact the existing congregation but could potentially deter newcomers from joining. Nevertheless, KJ reported that he and his congregation became more accustomed to the behaviors until the person eventually stopped coming.

Six months later, the pastor encountered the individual on the street, and she shared that she had been hospitalized in a psychiatric unit because her neighbor had reported her to the police for loud yelling. She mentioned that she would move into a nursing home soon and thanked him for allowing her to attend his church, unlike other churches.

KJ describes the church steering committee's approach towards the woman with schizophrenia and their decision to include her in the church as both surprisingly gratifying and realistically challenging. While he foresees the continuing negative impacts of her behaviors during worship services and anticipates challenges, he finds the congregation's decision to accept her in accordance with his understanding of the essence of Christianity:

> **KJ:** After the second week of the individual attending Sunday worship, lay leaders gathered for a steering committee meeting. At that point in the church's timeline, more new families visited us. Since a growing number of new families had registered during that time, the steering committee held an extensive meeting to discuss how to handle the situation with this lady. Unfortunately, I wasn't present at the steering committee meeting due to prior commitments. When the meeting concluded, I asked about their decision.

> They explained, “It won't be easy to expect new visitors to join us, as the services might be interrupted for a while [as long as the individual attends and continues the behaviors]. These newcomers will be welcomed at any other church, but not this lady. So, we have decided to take her in.” When the steering chairperson informed me about this decision, I chuckled brightly and jokingly complained, “How could I minister to this church when you’re making such a difficult decision? Would you make the same decision if you were a pastor?” But that was one of the happiest Sundays of my life. I felt comforted, realizing that my efforts [as a pastor] were not in vain, and my life [as a pastor] hadn’t been in vain.

KJ’s, as well as the church’s, experience with the woman was tumultuous, depending on her condition, which fluctuated daily. The committee’s decision was not followed by any drastic changes or attempts to accommodate the woman, although the pastors and some church members did strive to learn more about schizophrenia. KJ assumed it would become more challenging for him and the church, and thought more existing members would have left the congregation, if the woman had stayed much longer and increased her participation in other church activities besides worship. KJ and his church were not fully prepared to embrace someone with schizophrenia. However, aligned beliefs and values about the purpose of the church between the pastor and the congregation led them to strive together towards a vision of including her as a legitimate member of their church, despite foreseen challenges and disturbances.

KJ's belief in appreciating hardship accompanied by the practice of faith has been disclosed several times in his positive evaluation of the experience. KJ is one of the participants who described the encountered individuals with schizophrenia as “[God’s] gift.” He reports the deepening and widening of his own and his faith community’s perspectives on human beings, the

church as a community, and the Christian faith gained through the encounter. KJ believes that individual and congregational growth can be achieved by living with people with mental illnesses or other disabilities and proactively learning about and affirming human differences. He clarifies that not all clergy and churches can or should adopt this view due to their diverse religious values and that his approach may not be universally applicable and may even run counter to the goal of "growing the church."

JH's Narrative

JH, the only female interviewee, is a Korean Methodist pastor in her 40s. She has led a faith community of 15 individuals, comprising male and female young adults in rural areas of South Korea, since the 2010s. The community maintains a communal lifestyle that combines labor, including farming, missional works in the village and other churches, and Christian devotional activities. During the 2010s, the community was joined by two different individuals—one female and one male—at different times, both previously diagnosed or showing signs of having schizophrenia. The former stayed in the community for four months, while the latter left after spending four years with the community.

JH expressed that the most challenging moments were when other church members became fearful or complained about the excessive unconventional—yet non-violent—behaviors of these members. These individuals continuously shared or displayed emotional expressions based on their beliefs of being pursued by an imminent threat, facing persecution, or being loved by someone in the community, alternately one by one. These occurrences were reliably denied, but JH had to manage their repercussions on others in the community. One individual was eventually hospitalized by her parents, even as JH desired to keep the member in the community and provide spiritual support for her recovery. The other left voluntarily after facing rejection

when asking another community member on a date. In addition to these encounters, two relatives of the pastor, both diagnosed with intellectual disorders and schizophrenia, joined the community but disrupted community members and neighbors and later chose to leave the community.

The church members JH ministers voluntarily live together, sharing a common interest in practicing Christian faith through a communal, holistic religious lifestyle. JH indicates that each member's commitment has heightened their willingness to tolerate distress, discomfort, or conflict from sharing life with others. According to JH, the community's practiced tolerance, motivated by their faith, reduced direct slander, reproach, or rejection towards individuals experiencing schizophrenia. Meanwhile, community members relied on her to mediate their negative experiences with the church member causing discomfort or distress to them. JH admitted she felt a lot of pressure from the high expectations on her to resolve every issue that arose, but in the long run, it was worth it.

Echoing her belief that the church is a community of love that accepts people as they are, the experiences with these individuals hold positive significance for JH and other community members. She emphasizes the significance of the community in the social and spiritual recovery of the two community members, manifested in their continuous engagement with the community:

> **JH:** So, the first person, during her time with us, went through a really tough time… It's probably the community she least wanted to revisit--the one where you've shared the most embarrassing and ugly parts of your life, the stuff you'd rather keep to yourself. But it turns out it's the community she misses the most, and it holds special importance for her. She often thinks about the time she spent here, so she comes back occasionally and gets in touch. It's great to see that she's doing well and returning to her normal life. Even

> if she didn't experience big, miraculous healing or recovery while she was with us, knowing that the community has been a supportive sanctuary for her during and after all that time, even though she lives somewhere else now, is encouraging to me personally… And then the second person, as I mentioned, hadn't been able to face himself at all. But now [after 4-5 years], at least, he's become aware of his illness. I consider this a significant development, even if it's just a small change... a crucial turning point in the healing process. This is why I believe the community is so significant—it played a vital role in providing feedback to this person through interactions with others [during his time in the community].

JH unequivocally admits that dealing with the erratic, repetitive, and, at times, aggressive words and behaviors of the individuals consumed a lot of her time and energy, taking a heavy emotional and mental toll. This raised concerns among people around her regarding her personal well-being and the prospect of her ministry. Even so, like KJ, JH used the term "gift" to affirm the opportunity engaging with individuals experiencing schizophrenia—and the challenges this entailed—gave her to mature her faith and learn to genuinely love others, both individually and as a community.

WJ's Narrative

The context of WJ's spiritual care interaction with a person with schizophrenia differs from the other research participants. A Korean male in his 40s and a Holiness Church pastor, WJ also served as a military chaplain during the 2000s. While serving, WJ encountered a Korean male in his 20s fulfilling his military obligation, who had been referred to him due to suspicions he was demon-possessed. The individual had just returned from vacation and experienced a serious conflict with his father. Under tremendous pressure and stress from the incident and

military life, the soldier began seeing things that didn't exist, hearing voices commanding self-harm, and exhibiting highly suicidal tendencies. WJ directed the individual to a military hospital, not attributing the behaviors to demon possession but recognizing them as symptoms of schizophrenia. The subsequent diagnosis for the individual was indeed schizophrenia.

Upon the soldier's return to the barracks after receiving treatment, WJ was assigned a pastoral assistance position to be carried out by him at the military church and spent six months supporting the individual's recovery. WJ continued to provide care until he was reassigned to a different regiment, observing visible signs of stability and improvement in the individual's recovery from hallucinatory experiences and self-harming tendencies.

In this case, WJ's context was non-civilian, and with his rank, he could garner more control and authority to order care arrangements for the individual, making it easier for him than the other pastors discussed to change the environment into one conducive to support the individual. WJ's encounter was narrated positively, assumedly because the course and prognosis were good, specific challenges were addressed, and he was moved by the soldier's strong will to recover. Furthermore, the encounter reminded him of his wounds from childhood domestic violence experiences, through which he could empathize more with the person. WJ admired and was healed and inspired by the person's will to break from his schizophrenia. One thing that stood out is WJ's view on the lived experience of the soldier. WJ used the term "disaster" to convey how the experience of schizophrenia is entirely unpredictable and cannot be attributed to or blamed on anyone, although he suspects it is linked with high stress and violence, which he mentioned in parts of his interview:

> **WJ:** Neither his parents, even his abusive father, nor himself wanted [him to experience schizophrenia]. He didn't undergo it willingly; rather, it just happened by chance. He

found himself in this situation against his will, and that's the only reason he got sick. It's not his fault.

WJ shared one more case from his parish ministry experience. However, it seems to me to be a case of delirium caused by alcohol addiction due to its brief period and other evidence. Since I could not identify or conjecture a conclusive diagnosis based only on the report, I decided to exclude it from my research reporting. However, the account does offer a glimpse into WJ's theological views on schizophrenia, which will be presented in chapter 5.

Expectation Versus Reality

Before delving into the diverse dilemmatic experiences the research participants encountered in their pastoral interactions with individuals exhibiting behaviors of schizophrenia, it is worthwhile to briefly outline the factors that contribute to various types of dilemmas. In coding of pastors' relevant pastoral care experiences with individuals with lived experiences of schizophrenia, four codes related to discrepancies between related understandings and practices emerged: 1) pastors' general and theological understandings of schizophrenia; 2) their perspectives on how Korean society and the church perceive those living with it; 3) the pastoral and ecclesial roles they envisioned for themselves and their communities; and 4) the spiritual care they implemented. Within these dynamics, pastors, in their role as spiritual caregivers, often found themselves entangled in dilemmatic situations of various natures. The dynamics between their different thoughts on and realities of spiritual care of people with schizophrenia are encapsulated by the overarching theme of "Expectation Versus Reality."

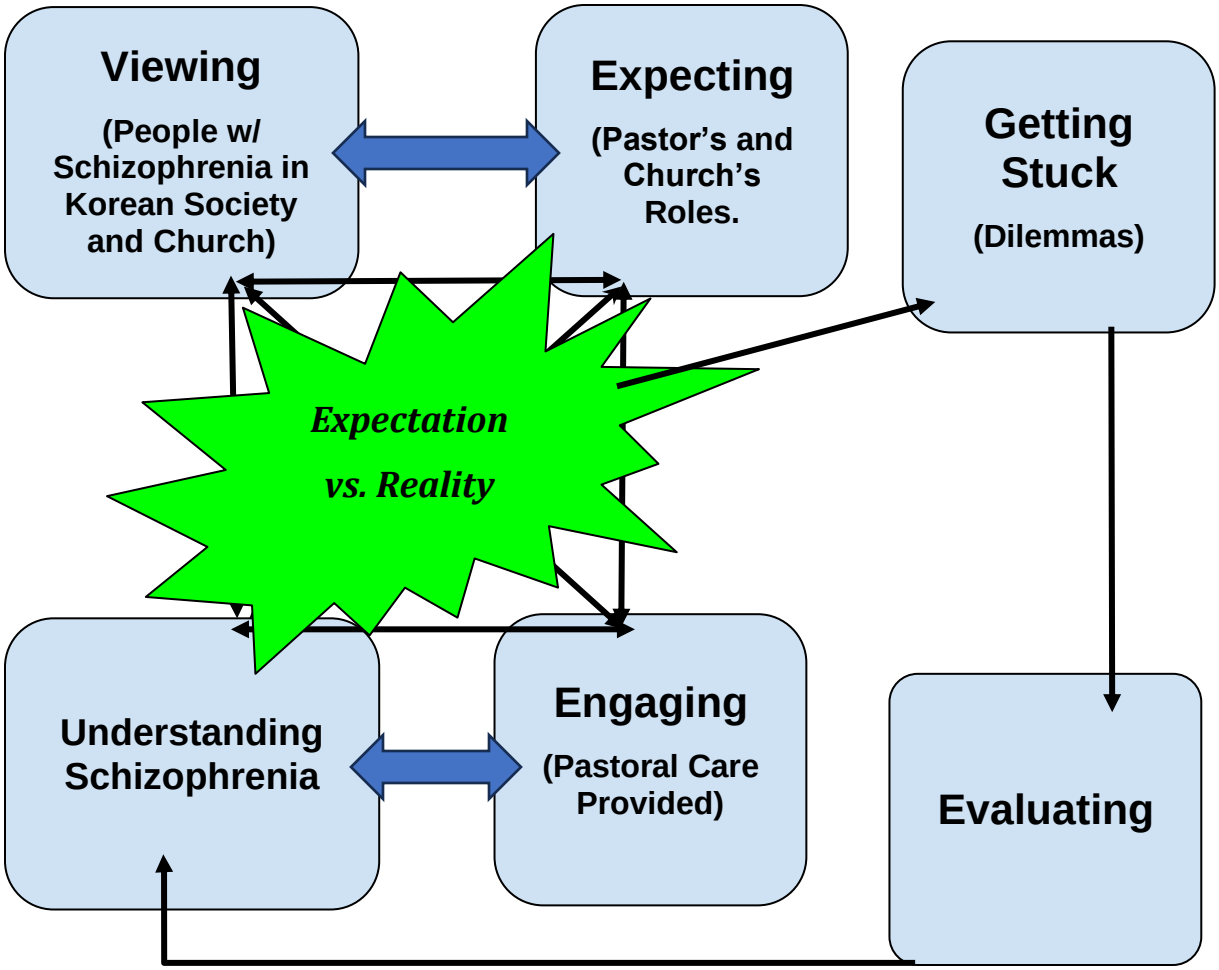

Figure 1. Diagram of the relationships among six code groups

Pastors' Views on Schizophrenia

1) General understanding of schizophrenia

Pastors' perspectives on schizophrenia were grounded in their understanding of the nature of the illness, and this, in turn, influenced their approach to addressing the issues that emerge with it. Pastors' understanding of schizophrenia consisted of both general and theological views. These were interrelated, mutually influencing how the pastors discerned the roles of pastors in the spiritual care of individuals with schizophrenia. While some pastors did not fully disclose how they comprehend the nature of schizophrenia, their orientation toward the spiritual

care available and/or preferable revealed their perception regarding this unfamiliar area of human experience. Based on their views, I divided the pastors into three groups.

The first group of pastors—HL, WJ, HC, SH—viewed schizophrenia as a purely medical phenomenon. They believed it should primarily be addressed through medical and psychiatric treatments, with the assistance of spiritual care if available. This group prioritized medical intervention over other approaches to help, care, and healing based on their understanding that the issues diagnosed and defined by psychiatry were central to people's lived experience with schizophrenia and, therefore, should be treated and resolved before addressing other concerns. As a result, the group tended to downplay the role of spiritual care or restrict it to traditional pastoral activities, such as offering spiritual support through prayer and worship. While they vaguely acknowledged the significance of faith and religion in healing and recovery, they did not spend time thinking about concrete ways religion/spirituality could be relevant and beneficial.

In contrast, the second group—JH and TR—believed schizophrenia, like other illnesses, disabilities, and human experiences, was fundamentally a spiritual experience, and therefore it should be primarily approached through a spiritual orientation with medical/pharmaceutical treatment being provided when needed. The participants in this group did not agree with or endorse ideas such as healing prayer or "cleansing" rituals for schizophrenia. There were different perspectives on medicine within this group. TR considered psychopharmacological intervention as essential in conjunction with spiritual care, while JH was suspicious of medicine, identifying its limitations by pointing out harmful side effects she had witnessed.

The last group maintained a comprehensive approach to schizophrenia—KJ. This group held a balanced perspective on the lived experience of schizophrenia, not inclined toward any specific paradigm. While other participants' reports also fit into this category—WJ, SH, TR, and

JH—they deviated by expressing their preference for either the medical or spiritual paradigm during their interviews. TR's position was subtle in some of his statements,[1] and had room for various interpretations. On the other hand, KJ consistently presented an inclusive attitude toward spirituality and psychology as equally significant dimensions of people's lived experiences with schizophrenia. This was also highlighted in KJ's emphasis on the distinctive roles of pastoral caregivers compared to those of psychiatric professionals. KJ recognized the need for collaboration between medical and pastoral professionals and how their practices can complement. What made KJ's position even more intriguing was that, when he entered the ministry, he was convinced that faith was the most influential factor governing the healing and recovery of people who are ill or disabled. The more he learned about the work of psychiatrists, psychologists, and counselors, the more "humble" he became, admitting that pastors need to avoid believing they should cure sick and ill believers by themselves:

> KJ: "This isn't within my area or expertise; I'll just refer them to psychiatrists." I think that's not right. However, asserting "I can fix this on my own," I believe that's not the right approach either.

Before moving on to the next part, one point is worth noting. In the reading of Christian pastors' narratives, we need to pay keen attention to the subtle nuances in their statements of faith and the impact these have on their views of schizophrenia. None of my research participants denied the necessity or benefit of the medical approach. At the same time, the pastors' statement that they believed God can or will cure schizophrenia did not necessarily rule out medical treatment options. Instead, it represented a religious or spiritual reflection of their experiences

[1] TR: "I believe that ultimate healing is only possible through God. If these people [people with mental disabilities] and their families agree with this, where they can truly confess to God, then I believe that the pathway to healing and recovery is available. So, I see medical treatment, the medical approach is secondary, not primary."

through their own belief system, expressed in accustomed religious languages, activated by the interaction with someone's lived experience of schizophrenia. It also simultaneously and sufficiently acknowledged other dimensions of reality in caring for the person—an example of "second naiveté," a term coined by Paul Ricœur.[2] Awareness of the multiple levels of language employed in faith statements hints at the specialized role that pastoral caregivers can play, as Doehring suggests, if they are fluent in navigating among these different languages.[3] The implication will be discussed in detail in Chapter 6.

2) Theological understanding of schizophrenia

While it remains uncertain whether the theological debate about why certain people randomly experience schizophrenia will ever reach a universally satisfying conclusion, it undeniably presents a highly sophisticated theological conundrum that stirs the curiosity of many, both with and without mental illnesses. Even the scientifically investigated and attested causes of schizophrenia—do not exhaustively explain the diversity of symptoms associated with people's lived experiences of schizophrenia.

Research participants shared their understandings of the theological causes of schizophrenia or, more broadly, illness as a human phenomenon. These understandings are grouped into four categories: 1) all illnesses, including schizophrenia, are related to a spiritual cause (HL, SH, JH); 2) there are no spiritual causes of schizophrenia, as it is caused by other factors (HL, TR, KJ, HC); 3) schizophrenia, as a mental illness, is likened to accidents or disasters that people inevitably and unwantedly get involved in (WJ); 4) like other unexplainable human experiences, schizophrenia is a mystery of God (HL, SH). None of the respondents connected schizophrenia to sins or unclean/violated spiritual conditions that make the individuals

[2] Doehring, *The Practice of Pastoral Care*, 191; Further discussion will be presented in Chapter 8.
[3] Doehring, *The Practice of Pastoral Care*, 99-100.

they encountered deserving of their suffering. HL believed human illnesses can be triggered and developed in multiple ways, not necessarily always activated by sin or negative spiritual causes. JH provided an intriguing perspective, attributing an individual's illness to the sins of the community, which Hessamfar propounds in her book.[4] The responses imply that, at least among the pastors interviewed, there was an avoidance of establishing a theological argument for a direct causal relationships between an individual's sin(s) or wrongdoings and the lived experience of schizophrenia. The research findings highlight the difficulty of tracking and identifying spiritual causes of schizophrenia, and thus, the interviewees appeared to be neutral to someone's lived experience of schizophrenia. However, this will be further investigated in regard to their understanding of the phenomenon of demon-possession.

Similar to their ambiguity about the theological causes of schizophrenia, even though they acknowledged the spiritual dimension of people's lived experiences with schizophrenia, the implications and significance of this dimension in an individual's overall experience with schizophrenia were diminished and/or overlooked (HL, WJ), only vaguely recognized (SH, HC), or affirmed but not detailed or addressed (KJ). Their understandings were rooted in a sense of urgency to address the symptoms and behavioral/social impacts of schizophrenia, prioritizing these as having the greatest impact on the wellbeing of the individuals with this lived experience. TR attended to the social suffering of schizophrenia, deeply embedded with his theological understanding of society's deep-seated problem of not accepting those affected by schizophrenia, and had developed and practiced his theory of spiritual care for individuals with schizophrenia, grounded in his psychological, counseling training. While TR's approach included addressing an

[4] Hessamfar, *In the Fellowship of His Suffering*, 203-06.

individuals' spiritual life in relation to their overall lived experiences of schizophrenia, this was not his primary focus:

> Minhwan: During your meetings with them, was it more faith-based counseling or faith-based conversation? Were there specific topics or themes that you primarily addressed in counseling or group conversations with them?
>
> TR: Well, it begins with faith, although I wouldn't say it's the main focus. I received training at a place called [omitted for confidentiality], which is now a non-religious counseling institute. They had a [omitted for confidentiality] program, and during our meetings, I introduced and utilized it for participants. We covered different topics and aspects of their lives, and I provided counseling and advice, emphasizing their stories through the program; and prayed for them.

JH had an interest in and sought a comprehensive approach to the spiritual direction, including for those living with schizophrenia, but she admitted her approach was not fully informed about the lived experience of schizophrenia, both theoretically or practically.

Unlike the disparity and obscurity in views regarding the theological nature of schizophrenia as a human experience, all participants clearly expressed their awareness of religious/spiritual imperatives of care for those whose experiences with schizophrenia have led to marginalization and alienation in society. This was well-illustrated in how one pastor labeled it as the "Lord's demand [to care for people with mental illness]" (KJ). Some respondents explicitly asserted that the Church has been given an irrefutable mission and responsibility to care for individuals with experiences of marginalization in society, including those living with mental illnesses or disabilities (TR, KJ, JH). Their beliefs extended to the conviction of specialized roles and the domain of pastoral care, whether carried out by the pastor, the church,

or both, in caring for and assisting in the healing and recovery of individuals, though detailed explanations were not provided. On the other hand, while upholding the church's mission for those who are socially oppressed and outcast, some participants skeptically raised doubts about the roles exclusively assigned to the church (HL, WJ, SH, HC). They called for more expansive and collaborative pastoral care interventions based on their analysis of schizophrenia as a medical phenomenon.[5] Except for TR, who had already established his own theological position on people with schizophrenia as "the Little Ones," (Matthew 18:10-14) the pastors agreed on the necessity of a new theological approach, indicating their uncertainties about how to comprehend schizophrenia theologically and how to effectively and adeptly care for people and their lived experiences within the Korean church context, both theoretically and practically.

Before concluding this section, one more topic regarding the pastors' theological views on schizophrenia deserves attention for further critical investigation: demon possession. All participants denied any relatedness between schizophrenia and demon possession, considering them as two distinct phenomena. However, except for HC, who adhered to his view that demon possessions in the Bible are mental illnesses in today's society, others acknowledged the biblical definition, not necessarily related to the traditional Korean cultural one, of demon possession as a valid and real spiritual experience separate from mental illnesses, sometimes even conflated (WJ, JH). Their pastoral experiences of responding to requests involving individuals believed to be possessed by demons and observing and addressing the individuals' expressions through the practice of deliberation rituals assured them of the existence of the phenomenon. They postulated a link between the atypical behaviors or experiences described as being possessed by ill-spirited entities and the influence of external negative spiritual forces or spiritual/mental weaknesses in

[5] For example, SH states, "To be blunt, there is none the church can do for them [people with schizophrenia]."

those who underwent such experiences. This loosely-tied connection, can unconsciously imply a continuing association between unaccustomed, negatively perceived mental experiences and suspicion of blamable causes, whether within or outside the experiencer.

People with Schizophrenia in Korean Society and Church

1) People with schizophrenia in Korean society

How did interviewees perceive the way Korean society and the church view people diagnosed with and/or experiencing schizophrenia? All of them concurred that individuals with schizophrenia in Korean society experience a lower status compared to other minority groups, including those with other types of disabilities. They attributed this phenomenon to widespread public ignorance, indifference, and misinformation around individuals identified with schizophrenia through psychiatric diagnosis or unconventional behaviors. They reported that people with schizophrenia frequently face stigma and are subjected to numerous negative stereotypes in Korean society.

For example, KJ and JH noted one of the most commonly used derogatory terms for a person or group of people with mental illness in Korean society is “jeongsinbyeongja,” as mentioned by the interviewees. Beyond its literal meaning as a “mental patient” in Korean, this term maliciously connotes a “psychopath.” The negative social image of individuals with schizophrenia as “crazy individuals”—violent, treacherous beings causing discomfort, inconvenience, interference, and harm—results in their being perceived as an imminent liability or threat and, therefore, someone to avoid (SH, TR, KJ, JH, HC). Some of the pastors further connected the reinforcement of this stigma and the consequential public belief in segregation to the media’s biased portrayal of incidents that highlight a perpetrator’s diagnosis of schizophrenia (TR, JH, HC).

Respondents also noted the long-held Korean cultural belief that individuals with schizophrenia are held directly or indirectly responsible and deserving for their experiences or suffering. One enduring Korean traditional shamanistic belief, as indicated by the interviewees, is the concept of "sinbyŏng," where individuals being possessed and cursed by an evil spirit are seen as experiencing a form of sickness (SH, TR, KJ, HC). They agreed that this belief—that those possessed are thought to harm or spread negative and ill-spirited influences on others—continues to implicitly pervade and linger, causing disgust, hatred, and fear in the public.

They also reported that the Korean cultural tendency to view differences from the majority as deviations from cultural standards of being "normal," either to comply or avoid breaking them, continues to be used to justify the ostracization of certain individuals, including those with schizophrenia (WJ, KJ). Interviewees added that this tendency explains why people in Korean society are highly sensitive to others' views of them. Differences, whether conveyed through the person's display of socially unacceptable behaviors or the disclosure of one's stigmatized diagnosis, often further exacerbate the mistreatment and non-acceptance of individuals with schizophrenia.

All interviewees unequivocally expressed their view of Korean society as harshly discriminating against people living with schizophrenia more than towards groups with physical or mental disabilities (whose social accommodation is also unjustly insufficient). This discrimination varies from distorted and negative public assumptions and the lack of social, economic, and medical accommodations to the underestimation of their capabilities, and consequently, unfair withholding of social, economic, cultural, and vocational opportunities. Reviewing the pastors' understanding of Korean society further elucidates the implications of specific responses from interviews such as why disclosing one's own or their family member's

schizophrenia is tremendously challenging and risky in Korean society and why the chance of encountering individuals with schizophrenia in daily life is particularly rare.

2) People with Schizophrenia in Korean church

Interviewees expressed their opinion that perceptions of schizophrenia in the Korean church are no different, or even worse (KJ), than those in society. Convinced that most Korean pastors and churches do not have any interest in knowing or living with people with schizophrenia and/or merely want to avoid them, all participants agreed with the prevalence of a denigrating and exclusive attitude in the Korean church towards people with mental illnesses, including schizophrenia.

Interviewees unanimously attributed the primary cause of this to the lack of a clear understanding of schizophrenia by both clergy and congregants. Prejudices within the church were identified as well, such as the perception of people with schizophrenia as an irritating, incompetent, detrimental, or dangerous and therefore, unfit for the (church) community, which is not dissimilar to the prejudicial stereotypes existing in Korean society. Consequently, people with schizophrenia were viewed as having a negative impact on other church members and as those who hinder the growth of a congregation (HL, TR, KJ, JH, HC).

Some of the interviewees also pointed out the negative religious stigma against people with schizophrenia in the Korean church, such as demon possession (HC), God's punishment, or resulting from of sinful behavior (KJ). These beliefs have created a judgmental, hostile environment for individuals disclosing their diagnosis and/or displaying expressions of schizophrenia within a church.

All interviewees noted the absence of a caring system or structure, preparation, resources, or even the mere intention of pastors and congregations to care for and embrace people with

mental disabilities, including schizophrenia, in most churches. For instance, in Korea, church buildings are mandated by legislation to install accommodations for individuals in wheelchairs and those who have other physical disabilities, but there are no legal requirements to assist people with mental disabilities (SH, HC). Some interviewees believed the ideal of the church community proactively caring for minorities, such as people with schizophrenia, clashes with the realities many churches face. Therefore, this is a reason why these minorities are not openly welcomed by them (TR, KJ, JH, HC). Given this, they concluded that only a few churches have the capacity to run a special ministry to meet the religious/spiritual needs of, and take in, people with mental disabilities. The interviewees did not know of specific churches intentionally and strategically ministering to people with schizophrenia and other mental disabilities in a congregational setting, except for TR, who had consistently conducted research on this topic. Interviewees' views help explain the conclusion made by some pastors that the presence of someone with schizophrenia only increases the pressures and burdens on pastors (HL, SH, KJ), particularly within the relational dynamic with other congregants. This will be further discussed in the next chapter.

Pastors' and Church's Roles

Within the way they comprehended the human phenomenon of schizophrenia and the sociocultural and ecclesial views of those living with it, pastors recognized their self-anticipated pastoral goals and their goals for their faith community, but intriguingly, they did not mention goals for society as a whole. Another captivating point discovered during the interview was that, when asked about what they believed pastors and the church community can do to care for individuals with schizophrenia, participants frequently equated pastors with the church or vice versa. It is worth mentioning that some pastoral and church tasks, along with their goals, can be

conducted and achieved simultaneously through one specified approach mentioned by the pastor as an individual or by the community as a whole. For example, pastoral conversation may not be reduced to conversation per se but may include praying and emotional or relational support. In my coding, categorization was based on how participants named and described these practices, separating them as distinct tasks.

1) Pastoral Duties Anticipated

Interviewees provided a greater variety of roles pastors can perform in their pastoral interaction with a person experiencing schizophrenia, particularly compared to their expectations of the church. Reflecting their high self-expectation of pastoral responsibility, the list of roles provided was extensive. All respondents pointed to the task of providing welcome and acceptance, and hospitality to individuals with schizophrenia as a baseline expectation, though some displayed ambivalence towards this expected duty (HL, SH). Some pastors prioritized tasks categorized as traditional pastoral duties, such as pastoral conversations, making home visits, or praying, as most relevant (SH, KJ, JH); others focused more on providing relational/emotional, psychosocial, or practical assistance to aid in accessing medical treatment or helping with daily life (HL, WJ, TR, HC). Emotional assistance, including offering genuine interest and support, was the second most mentioned responsibility (HL, WJ, KJ, JH, HC). This was followed by actively referring to and linking with other professional/medical treatments (HL, WJ, SH, KJ), psychosocial support such as congregational education about mental health/illness (TR, KJ), and offering counseling services or psychosocial education (SH). Providing support for families of individuals with schizophrenia was explicitly mentioned only once (HL).

Some participants specified that pastors need to actively address individuals with schizophrenia and their behaviors and intervene if there is a relational conflict before they can

have negative influences on other lay members to ensure the safety of all involved (HL, SH, JH). With a similar intention of assisting individuals to develop positive relationships with other church members, some pastors highlighted the time and energy they spent diligently and patiently dealing one-on-one with those who have lived experiences of schizophrenia (TR, KJ, JH, HC) and helping them explore of religion/spirituality in a way that enhanced both their ordinary and spiritual life (JH). This also involved providing emotional comfort for congregation members who have witnessed or interacted with behaviors recognized as symptoms of schizophrenia (HL, KJ, JH). However, aside from KJ, these instances did not culminate in further pastoral care actions such as educating the congregation about mental health/illness.

2) Ecclesial Duties Anticipated

In terms of their expectations of the church as a faith community, the pastors did not elaborate on roles the community as a whole can play in caring for people diagnosed with/presumed to have schizophrenia. Most expectations participants mentioned involve the church as a venue that welcomes and embraces people experiencing pain and suffering with hospitality (SH, TR, KJ, JH). Some of them added that the church should be a space for individuals with schizophrenia to experience emotional and interpersonal interactions (TR, KJ, JH, HC). One pastor emphasized the need for more churches to run a special ministry for individuals with mental disabilities within their congregations (TR), while two respondents upheld the idea of an inclusive community that seeks mingling and sharing of life, to varying degrees, among people with and without mental illnesses, including schizophrenia (KJ, JH). Only one respondent assigned educating the congregation as the church's role instead of the pastor's (KJ).

While they anticipated numerous roles to assume as pastors, they identified fewer responsibilities for the faith community when it comes to the care of individuals with mental disabilities. Some interviewees even reported that they did not have any expectations for the church at large (HL, WJ, SH). This discrepancy suggests the disproportionately allocated burden of pastoral care on pastors, who bear the load without the community's proactive participation or support. There were no comments on the areas or contributions the church can make in working with a larger group beyond the individuals discussed or those who may be encountered in the future, within the church or outside in society.

Pastors' and Church's Actions

Research participants reported engaging in various types of pastoral care for individuals they encountered, including: 1) Traditional pastoral assistance; 2) Relational-emotional assistance; 3) Psychological assistance; 4) Assistance with daily life; 5) Community education; 6) Deliverance ministry; 7) Assistance with medical treatment; 8) Care/assistance to other congregants. The top three most reported caring interventions, excluding the last category, are traditional pastoral care activities such as worshipping together, holding pastoral conversations, and praying for the person (WJ, TR, KJ, JH, HC); providing relational-emotional assistance, providing welcome and hospitality, providing empathic, and listening affirmatively (WJ, TR, KJ, JH); and providing psychological assistance through psychological small group programs (WJ, TR).

One pastor mentioned that he was initially called upon to perform a deliverance ritual for a person with schizophrenia (WJ). Another pastor reported using the interaction as an opportunity to educate his congregation about schizophrenia (KJ). Yet another minister was comprehensively involved in assisting a church member with schizophrenia on all levels of daily

life, including arranging medical and social welfare support, as well as meeting basic needs such as washing and feeding him, due to the person's severely compromised capabilities (HC).

HL and SH reported no involvement in directly caring for individuals, citing different reasons, while they acknowledged some possible roles that pastors or the faith community can play. Due to the severity of the conflict for HL, he stated he focused on caring for other church members impacted by the incidents involving the individual's disturbing and damaging behaviors.

The rest of the pastors are divided into two groups based on whether their pastoral and ecclesial care expectations and engagements are aligned or dissonant in their encounters. One group perceived that their work and anticipations were mostly consistent (WJ, TR, KJ, HC), whereas the other found their expectations were too high to be actualized, given the resources they had (JH). This influenced how they evaluated their experiences, although other factors also contributed to their assessment.

Conclusion

The investigation into the intricate relationships among various relevant ideas, beliefs, and experiences of spiritual care for people with schizophrenia within the context of the Korean church provides a basis for understanding the interviewees' dilemmatic experiences in their pastoral practice of embracing and caring for these individuals, ultimately contributing to negative evaluations. With an understanding of this background, the pastors' dilemmatic experiences will be analyzed in the next chapter.

Chapter 5

Dilemmas in Pastoral Care of People with Schizophrenia

Introduction

Out of the various definitions for "dilemma," one conducive to our discussion is as follows: "a situation in which a difficult choice has to be made between two or more alternatives, especially ones that are equally undesirable."[1] Changing the wording from "undesirable" to "not impeccable," the definition of dilemma can be utilized to delineate the pastors' experiences with conflicting choices, decisional impasses, and the consequential avoidance of dealing with dilemmic issues, which often leads them to hastily choose a familiar option when providing pastoral care to people with schizophrenia in the Korean church. Various types of dilemmas can arise which lead pastors or congregations to feel dissatisfaction or regret during and after making pastoral caring decisions around individuals with schizophrenia. Each dilemma includes several patterns of interaction/incident/phenomenon, each of which share similar qualities that can be grouped respectively. It is worth stressing here that even if different pastors' experiences are categorized under the same type of dilemma, the causes of initiation, course of interaction, and/or outcomes vary due to the distinctive contexts of each pastor. Additionally, each category of dilemma is not exclusive; rather, they are all interrelated as the contributions and influences of contextual factors intersect. Consequently, some respondents provided self-contradicting, but understandable answers in their reports.

[1] Elizabeth Knowles, ed., *The Oxford Dictionary of Phrase and Fable*, 2nd ed. (New York: Oxford University Press, 2005), s.v. "dilemma."

1. Personal Dilemma

Personal dilemma indicates a personal-level conflict that arises when interactions with the behaviors of individuals with schizophrenia cause negative internal or external experiences in the pastor's personal life. This dilemma sometimes occurs and escalates due to role confusion or a sense of limitation. The personal dilemma is categorized to include four common patterns experienced by the research participants: 1) interference in personal life, 2) direct conflict with or attack by the individual, 3) personal limitations, and 4) negative feelings and pain. Personal dilemmas occurred most often in contexts where there were frequent contact/encounters with the individual, not limited to the church buildings. The individual's symptom-led behaviors intensified the conflicts or disturbances to the pastor's personal life (HL, JH, HC).

Apart from disruptions caused by individuals exhibiting behaviors or expressions of schizophrenia at the church, the intrusion into the pastors' personal lives had deteriorating impacts. In HL's case, the person persistently and excessively contacts the pastors and staff, including the interviewee, through texts and calls with condemning and harassing contents—up to a hundred every day, day and night—for weeks spread out over three months. These actions severely perturb and disturb their lives. In the communal living setting of her ministry, JH stated that listening to individuals with schizophrenia sharing their versions of stories about persecution or romance excessively consumed her time and energy, as well as that of her church members in their everyday lives. Similarly, HC's co-living with a church member with schizophrenia inevitably blurred the boundaries and intruded into HC's and his family's lives; for example, when the church member loudly and ceaselessly talked to himself and screamed day and night.

A more direct attack on the individual pastors is another case that imposes personal conflict. Among the interviewees, only HL experienced verbal and relational harassment.

Fortunately, these did not escalate into physical attacks. Nevertheless, the emotional damage and toll caused by stalking and bullying targeting the entire pastoral leadership was irreparable and multilateral. Although action was taken following his lead pastor's decision not to respond and avoid contact with the individual altogether, the dilemma of HL's struggle is more clearly shown by the fact that he could only resort to a passive approach to address the incident.

Being aware of their limitations in providing pastoral care for church members with schizophrenia has led them to challenging moments. This specifically includes the pastor's internal conflict between their personal and pastoral identities as they navigate different needs arising from the tumultuous interaction with the church member. Inundated by calls and texts at all times of day and night, coupled with the friction and confusion caused by the individual's attempts to impersonate him and alienate him from lay members, HL reported becoming overwhelmed at the time. Later, he shared that he felt disappointed in himself due to internal conflict, as it misaligned with his pastoral expectation of prioritizing the pastoral role over his emotions.

> HL: Should I admit that I was a little disappointed in myself on my journey to become a pastor? I had found myself predominantly filled with emotions experienced as a human being rather than as a pastor. I just had been filled with emotions such as frustration, irritation, and anger.

TR recalled his limitations as a *pro bono* pastor at his church at the time of his encounter with individuals experiencing schizophrenia. Given this, he was unable to invest significant time and energy into pastoring the assigned group, including visiting and ministering at their transitional care home on weekdays, due to the necessity to maintain another career to make a living.

The sense of being limited is also related to the pastors' awareness of falling short of their self-expectations. At the funeral of his church member, who had long been living with schizophrenia and during his interview, HC reported he could not shake away his sense of regret for not doing more to help with this individual's rehabilitation. HC regretted not encouraging and pushing the individual further and teaching him to work (instead of just letting him do whatever he wanted) and blamed himself for the individual's lack of progress. Conversely, JH felt constrained when those with mental illnesses, including schizophrenia, placed unrealistic expectations on her to play the role of a "Superwoman," miraculously resolving their issues and weaknesses.

Triggered by either one or a combination of the three patterns above initiated during the encounter/interaction, pastors experienced negative emotions, pain, and consequences. These emotions pertained to the pastors themselves, as individuals or in their pastoral roles, and to the individual who caused the conflict. The negative emotions entail worry, fear, hatred, irritation, anger, hurt, frustration, confusion, burden, feeling stuck, and sometimes even giving up hope. JH describes the emotional damage and wounds she endured from verbal and emotional attacks and the repetitive, emotionally draining, distressing behaviors of her church members with mental illnesses, including schizophrenia, as excruciatingly painful—pains that in some ways persist in her ministry to the community:

> JH: My testimony of them being gifts from God [church members with various mental illnesses] did not start from the beginning. It was extremely painful for me in the first seven or eight years, and I just forced myself to go through and tolerate it. I questioned how I would minister to a church if I couldn't love a single soul.

HC mentioned that he held onto hope for a long time, until he realized that the individual would never change, which left him emotionally plunged:

> HC: So, once [the person's] condition gets really bad, it's really hard to bounce back to a normal state. I kept hoping, like, maybe someday he'd recover himself and get his life back together. That was my expectation all along, but at some point, I had to let it go… He was just lying on the floor, stuck in his room all day, not moving or walking. That was tough emotionally [for me].

2. Pastoral Dilemma

Pastoral dilemma refers to confusing and contradictory moments pastors experience regarding their sense of limitation, lack of clarity, or perceived irrelevance in their roles as pastoral caregivers in providing care for individuals with schizophrenia. Additionally, it occurs when they realize a non-negligible difference between theory and practice. According to the interviews, the pastoral dilemma was experienced in the following ways: 1) perceiving only traditional pastoral activities as viable, 2) acknowledging that the condition of individuals with schizophrenia makes pastoral care seemingly impossible, and 3) struggling with a gap between theoretical understanding and practices of pastoral care.

Some pastors shared their frustration about the constraints they perceived around pastoral care that they believed limited the degree to which they could be helpful to individuals with schizophrenia. Only a few of the traditionally acknowledged roles of pastoral care, such as praying or pastoral conversation, are commonly believed to be valuable in the context of interacting with individuals with schizophrenia in the Korean church. Relying on traditional pastoral care roles is perceived as working within these limitations to offer them benefits ultimately. SH mentioned several times that praying for the affected individuals was the only

available means to support them pastorally and realistically. While his statements infer the subtle nuances of incompetency and powerlessness pastors can feel, he also affirms the significance of both the pastoral and church's traditional roles in the healing process for an individual with schizophrenia:

> SH: The church's got a job to do, too, and the best we can do is pray and ask God to heal those suffering from disease.

Going further, some pastors shared their belief that pastoral care is inconsequential or ineffective in certain contexts—such as with individuals with schizophrenia. This perspective is grounded upon their understanding that pastoral care is undeliverable/meaningless unless psychiatric, pharmaceutical, and psychotherapeutic treatment is provided first. Thus, they assess their contribution as a pastoral caregiver as minimal and inconsequential due to demoralizing their active participation (HL, SH).

Based on his psychological education, HL believes that providing pastoral care is only possible once medical treatment is provided. He sees the effort to refer individuals to medical professionals as more of a neighborly or citizen's duty than a pastoral one. Though maintaining a consistent view on the irrelevance of pastoral care, during the interview, he was able to solidify one concrete idea about the pastoral approach he would apply: pastors should deal with the disruptive expressions associated with a church member's schizophrenia to prevent them from negatively influencing others in the congregation:

> HL: I don't know how to deal with them pastorally, but I'm thinking about one thing I'm trying to apply to my ministry with them. I'm trying to prevent them from causing some discomfort in the community. But at the same time, I know they need to vent that way. Unless they're being treated through medication or other measures, even if they're

receiving counseling and medication, when it's not working well, they're going to have to vent it somewhere. If that's the case, shouldn't I be the primary target of that venting?

Meanwhile, although he believes in the significance of religion/spirituality as a healing mechanism, SH's statement that prayer is the only available form of effective pastoral care simultaneously conveys that the "church has nothing to offer" to people with schizophrenia. At the same time, other clinical or social work institutes do. SH's understanding is more bound to his assessment of the realities of Korean churches and pastors. Although he presents some ideas for pastoral care that could be offered if he were a senior pastor with control, he believes the range and availability of pastors in deciding and providing pastoral care to church members experiencing schizophrenia are circumscribed and constrained by the realistic challenges and resistances coming from the congregations they serve:

> SH: Pastors have to adapt to the congregation's situation and the church's atmosphere. Of course, pastors have a pastoral philosophy, but I think it will be decided by looking at the atmosphere of the church or the case within the church. If the congregation pays more attention to such people, I will focus on them and look for things I can do in the church. But if the church is a bit exclusionary, I can only adapt to it because that's the limit and reality.

Looking at a more specialized ministry context, WJ made it evident that he avoided establishing a pastor-congregant relationship with the schizophrenic individual he encountered because the condition of the soldier required extensive psychological and medical approaches:

> WJ: I purposely avoided having a pastor and a believer relationship. I told him, "you come to church and assist me, but you're doing this for your healing and recovery. That's the number one purpose."

With their different interpretations of the pastoral care relevant to healing and recovery, the discrepancy between theory and reality is considered to be a dilemmatic challenge for some of the pastors. TR's vision of practical theology, having its roots in the faith lives of people in the church, encountered apathetic responses from both the other pastor and the congregation in his church:

> TR: I was wondering why practical ministry failed in practice. I was confident the church would embrace these people and execute this ministry brilliantly, but I felt there were many barriers and couldn't do it as well as expected.

KJ stated that while he advocates for the religious value of striving to live together with individuals with schizophrenia, despite the challenges that may arise, he does not expect all other churches and Christians to adopt this approach because it can be difficult and even unrealistic in some contexts. JH shared the internal struggle, both she and community members experienced when they shared how their radical vision of the gospel—to love one another unboundedly—clashed with the inconveniences and distress involved in actually living this out.

3. Relational Dilemma

Relational dilemma describes the relational tension and strife generated within or among a pastor's relationships with individuals, other congregational members, and sometimes even their family members, especially when the pastor must assume the role of mediator. The subcodes for the relational dilemma are as follows: 1) interference/discomfort caused by conflict with others, 2) role conflict as an intermediary, and 3) no interaction (or developing only superficial relationships) with other church members. Pastors are caught in between during an interpersonal or communal-level conflict among individuals and other congregational members due to their relationships with both.

One of the relational dilemmas pastors encountered was when they had to intervene when a person identified as having schizophrenia caused disturbance, discomfort, or harm to other church members (HL, TR, KJ, JH). Although the behaviors of individuals experiencing schizophrenia manifest in different natures and forms, they impose varying degrees of adverse experiences on people in the faith community. In KJ's case, although it did not turn into a physical, violent incident, the new church member displayed aggressive, intense, and strident reactions whenever people tried to stop her. Even when not interrupted, she disrupted the whole service at times, causing others distress. In JH's community, there was more embarrassment and fearful reactions from the community members towards the identified individual's remarks and emotional expressions. In HL's case, the stalking of a pastor led to fear, disgust, and anger within the community as a whole. While TR demonstrates a greater understanding of the behaviors attributed to schizophrenia, these actions alarmed or embarrassed other congregants, leading him to function as a bridge to resolve misunderstandings. Except for HL, who was more convinced of the value of protecting their congregation's young people at that time, other respondents were caught in internal struggles for how to address the negative consequences of behaviors believed to be schizophrenia-related in their congregation. This dilemma was exacerbated, notably when pastors foresaw a high chance of its recurrence:

> KJ: If God sent her to us, He would want our church to become a close-knit faith community of mature believers. I had been preparing for that because, as time went on, more people were expected to leave—most of the people.

Assuming pastoral responsibility for everyone in the faith community, pastors are frequently placed in the unwanted role of mediating between two or more groups, requiring divided and unbiased attention to be given to all parties involved. Given the communal living

aspect of JH's faith community, this dilemma was common in their case. Having varying degrees of emotional reactions triggered by the romantic or persecutory beliefs and actions of the members with schizophrenia, many members of JH's faith community requested pastoral counseling from her, which took up a substantial amount of her time in personal and pastoral areas. Therefore, it is not surprising that she had reservations about inviting the member back into the community (or welcoming another individual with schizophrenia into the community), being aware of the struggle she might have to go through all over again:

> JH: I still invite him to come back, telling him "I'm waiting for you" and to stop wandering alone. I'd be lying if I said it wouldn't be tough because they [former members with schizophrenia] would be causing all the other community members to struggle, and they'd all be coming to me for counseling. So, it would be challenging, but...

In this dilemmatic situation, it often turns out that pastors have unrealistic expectations from their community, who see them almost as a "Superwoman," as JH labels it, someone who can and should resolve all tension and conflict in the community. HL and KJ share resonating accounts of the overblown demands they were faced with from their congregations.

The last pattern of relational dilemma is in stark contrast to the relational experiences described above; the congregation either shunned individuals and groups with schizophrenia or merely engaged with them on a very superficial level. Not all cases related to this pattern explicitly recognize the pattern as problematic (SH, HC); however, through frequent use of the term "walls," which signifies negative psychological distance, throughout the interview, TR perceives it as a significant barrier, not only preventing people with mental illnesses from joining the church but also exacerbating the social suffering of these people:

TR: For instance, during the community meal after Sunday worship, it would be ideal for all members to sit together at the table and have a meal while engaging in conversation. However, no church members had approached the group to do so, which felt like there were "walls" between them. This has led to members only sticking amongst themselves, out of a sense of walls. There were few people coming close to talk to them; they had to eat alone, separated from others, and move around as a group in the church.

4. Theological Dilemma

For pastoral caregivers, their theological foundation is the grounds for understanding and approaching a care receiver's lived experience on multiple levels, including the religious/spiritual dimension. When it comes to mental illness, including schizophrenia, the pastors interviewed often presented an ambiguous, simplistic, or insufficient theological comprehension of the experiences of those with schizophrenia,[2] posing its irrelevance or potential harms/disadvantages in pastoral care. Three patterns identify theological dilemmas reported by the research participants: 1) the difficulty of theologically defining the schizophrenia phenomenon (definition), 2) the difficulty of identifying the theological cause of the schizophrenia phenomenon (etiology), and 3) the difficulty of conceptualizing how to address the schizophrenia phenomenon theologically (intervention).

A number of pastors indicated they grapple with the challenge of theologically comprehending schizophrenia as a human phenomenon (HL, WJ, KJ). Leaning towards a psychiatric understanding or sociocultural images of schizophrenia and with little knowledge and

[2] These patterns are categorized according to the criteria identified in the comments of the research participants. Ambiguous theology refers to instances where self-contradictory statements or ideas are presented. Simplistic theology pertains to the portrayal of religious concepts of universal Christian virtues but lacks their application to the specific care of individuals with schizophrenia (e.g., the notion of loving one's neighbor). Lastly, insufficient theology involves the presentation of a specific theological argument or statement regarding people's experience of schizophrenia or their care, but without full explication or providing sufficient theological grounds or explanations.

direct experience with people who live with it, they lack or pass up the opportunity to develop a theological construction around it. HL, WJ, and KJ unanimously asserted that the experiences of the schizophrenic individuals they encountered should not be equated with traditional theological explanations, such as being result of the individual's or relatives' sins, impure spiritual conditions, or punishment from God. However, HL and WJ present their opinion that some cases might be related to traditional theological explanations. HL propounds his theological theory that all illnesses, including schizophrenia, result from one of three cases: either one's own or someone else's sins, the will of God, or random incidents. However, he repeatedly emphasized that he has not reached a biblical, theological, and religiously conclusive understanding of the nature, meaning, and implication of the experience of schizophrenia, despite his previous contact with individuals identified with the condition:

> HL: Bible-wise, theology-wise, faith-wise, I still don't feel like I'll be able to encounter another person with schizophrenia with a clear answer or an alternative approach… I'll approach each new person as if it's my first time, feeling flustered and just having to go with the situation.

Debriefing about another encounter he suspected to be a case of schizophrenia, WJ presents his understanding of the possibility of conflating or confusing spiritual and mental illnesses. While highlighting the difficulty of distinguishing between these experiences, his approach does not delve further into the theological dimensions of mental illnesses in this case, such as whether one causes the other or how they may influence each other.[3] On the other hand, KJ resolutely opposes traditional theological constructions that "alienate and marginalize people with schizophrenia and their families," calling for a new theology of mental illness, including

[3] This case will be further explored in the theological dilemma section of Chapter 6.

schizophrenia. This new approach refrains from defining these conditions as “the curse of God” or “God’s punishment”; however, he does not specify how it could be conceptualized.

The dilemmatic challenge of constructing a theological understanding of schizophrenia extends to identifying what causes or contributes to the experience of schizophrenia, i.e., theological etiology, if there is any (HL, WJ, JH). In line with HL’s more general views, stated above, while sharing the story of person at another church suspected having a schizophrenia, WJ obliquely implies the chance of one’s impure spiritual condition being directly or indirectly linked to mental illness experiences, not necessarily confirming or denying whether it could be applied to all cases of schizophrenia:

> Minhwan: Do you think some spiritual problem causes some people with mental illnesses?...
>
> WJ: Well, in another case I had, that’s precisely what it was. There was a schizophrenic guy I dealt with when I was an associate pastor… He had alcoholism... And it turns out he was a sex offender, which I found out later; it was after he had served his time for that already. I don’t know, but he kept saying he did wrong to his mother without specifying what he did wrong against her. I had a suspicion that it was related in that way... what could he have done more wrong for saying that?

JH presents views on justice that are less punitive, but still include an expanded consideration of spiritual causes. This includes factors like one’s spiritual relationship with God through family, or communal sins on various levels that may contribute to schizophrenia. The common dilemma found is that the mentioned causes are often only attributed or projected, without being confirmed or verified.

Lastly, pastors also describe developing a concrete idea of how to address someone's schizophrenia experience theologically as a dilemmatic struggle (HL, SH). Besides those who had already built their own theological position (TR, KJ, JH) or focus more on a practical approach (WJ, HC), while displaying a broader understanding of pastoral duties for the persons in crisis in general, respondents stated the necessity to discover more elaborate and detailed ways to implement their pastoral care for individuals with schizophrenia, in line with other helping and healing arrangements. SH's statement sums up this theological struggle well:

> SH: But it's a secular perception that schizophrenia is a disease; as a pastor, I firmly believe there's a spiritual aspect to it. So, I believe it can be spiritually fixable. Now, the dilemma is: does it have to be addressed with medication, or can it be resolved through prayer alone? The theological question becomes, do you have to take pills, or can you simply pray it away? From my theological standpoint, grounded in my studies, I believe we have to address it through both. There's a realm where God can intervene to bring healing, and the church has a role to play. But realistically, prayer seems to be the only viable option.

5. Ethical Dilemma

While all the other dilemmas presented here entail a fundamental acceptance/rejection of people with schizophrenia at their core, this category of dilemma specifically indicates conflicting situations that arise during the process of a pastor or congregation making a deliberate decision to include or exclude a person with schizophrenia from their community. While three interview cases did not require an intentional decision to be made on the part of the minister or their church (WJ, TR, JH), respondents in four cases commented that an inner or external struggle arose when, making the decision.

Despite the initial commitment by KJ and his congregation to embrace the female church member with schizophrenia in their church, KJ points out the congregation's dual, contradicting expectations of their church as a faith community:

> KJ: It's really frustrating for the congregation when a service keeps getting interrupted. People in the congregation feel annoyed and bothered when someone is loud and distracting during the service. But, you know, they also say the church shouldn't kick out folks with mental illnesses, shouldn't shut them down, and definitely shouldn't call the cops on them. The congregation is dealing with this inner struggle, torn between two minds. It would be easier to let go of one, but it's not that simple for them. To be frank, if you're bringing someone with schizophrenia into your community, you've got to let go of any ambitions for community growth.

Although the mutually agreed upon decision was spiritually and ethically value-driven, its repercussions have had continuous ripple effects on their religious life in the faith community. As KJ stressed, the decision to welcome the individual had long-term impacts on the direction of the community. They were faced with the decision to restructure the community to accommodate the needs of one individual with schizophrenia instead of the needs of potential new members, which became an ethical question the pastor and community as a whole had to address.

HC's radical decision to live with the individual with schizophrenia— whose ability to sustain daily life by himself was severely compromised—drew resistance, concern, and criticism from his family and fellow pastors. His decision resulted from witnessing the harsh reality of the mental health system in South Korea, where, until recently, and still outside Seoul, the only available option for a person with schizophrenia is inpatient hospitalization. For various reasons, his decision to live with the person, grounded in an ethical belief, was not positively received by

those around him, except for his spouse who has been supportive from the beginning, and parish members who had not interacted with them much, even though they had known the individual since they were young.

On the other hand, both respondents, HL and SH, whose pastoral leadership and congregations consciously chose to exclude, or at least be not more proactively inclusive of, individuals living with schizophrenia, agreed with the rationales behind the decisions made. However, at some point during their interviews, they expressed regret for not taking the initiative to embrace them more. HL firmly believes that the decision to avoid and lead the person to "voluntarily" leave can be justified for the sake of his parish members. Simultaneously, he is aware of the collision between two values, which incurs an ethical violation of his beliefs:

> HL: Now that I've been in the ministry for about a decade, at this point in my life, and during the interview, as I reflect on and examine the past, I question whether I could have embraced the individual more as a pastor back then. However, honestly, if faced with a new person like him, I'm still unsure if I could hold and protect them.

Nevertheless, this awareness did not evolve into concrete plans for future occasions that might require a reconsideration of inclusivity within the church. Reflecting on the covert and insidious discriminatory culture within the Korean Church towards people with mental illness, SH's ethical struggle over his hypothetical decision is, instead of a values conflict, more about how well-aligned and realistic his decision would be with reality of his congregational context which are in part based on the influence of Korean socio-cultural features:

> SH: I think, as a pastor, I'm going to try my best not to discriminate against him [the church member with schizophrenia], but I don't think it's going to be easy in reality. I'm well aware of the nondiscrimination principle. I recognize it. But, you know, as I said

before, can I appoint this person as a deacon? If I were the senior pastor, I think I could not.

6. Cultural-Epistemic Dilemma

Specific culturally or religiously constructed ideas or images within Korean contexts of a person diagnosed with or acknowledged to be experiencing schizophrenia can conflict with the practice of pastoral care. The cultural-epistemic dilemmatic moment occurs in the following forms when perceiving the person as one: 1) who is fundamentally problematic or defected, 2) who causes problems to others, 3) who is unpredictable and dangerous, 4) whose experience is better/worse than those with other illnesses/disabilities, and 5) none who has no experience that can be positively acknowledged.

The most reported cultural-epistemic view presented by the pastors is that the individual is fundamentally troubled or their condition is irrecoverably flawed. The people encountered in each church presented diverse forms, extents, courses, and frequencies of behaviors or expressions associated with schizophrenia, as well as caused differing degrees of impact on self, others, and the community as a whole. Regardless of these differences, assigning psychiatric diagnostic descriptions of schizophrenia to the individual or their actions renders them inferior and different from others without this label. WJ's prejudicial view, shaped by the impressions of patients in psychiatric hospitals, labeling them as "fundamentally abnormal" beings, exemplifies this dilemma. Paradoxically, his bias served to prevent assigning the soldier he took into his care to the stigmatized group:

> WJ: [In the psychiatric ward] I noticed certain facial expressions [of the patients] different from normal people… I sensed that he [the soldier] could escape the stigma, so I told people, "he is just unwell for a while; he is not fundamentally abnormal."

In SH's case, he initially normalized the layperson's behaviors during worship, identifying them with those driven by the Holy Spirit. Ever since acknowledging the diagnosis of the person though, his evaluation of the behaviors turned from faith-driven to pathological:

> SH: I noticed them [the lay member's behaviors], but Korean churches are very open about it. During the praise and worship, people stand, sing, and pray out loud and in unison because Korean churches are very accepting of those expressions. I didn't ask anyone, but I didn't find these behaviors strange.

Furthermore, SH's assessment of the lay members being disqualified for a leadership position due to lacking required capabilities was made based only on his observations—not from close interactions—and the stereotype that a person living with schizophrenia lacks relational capabilities:

> SH: But I learned that this person has schizophrenia. According to the Book of Discipline, a deacon is a leader who, when appointed, is expected to lead the class and teach the Bible. He couldn't fulfill these responsibilities, so I can provide a valid reason for why he can't be in that role.

The dilemma initiated by the view of individuals causing nuisances and troubles for others and communities was also prevalently reported, followed by fear and concern. HL's perspective on people with mental illnesses venting their symptomatic expressions and negatively influencing others, as presented above, illustrates the epistemic grounds upon which he reaches that conclusion. Although the senior pastor made an inclusive decision, unlike other churches that rejected the group, TR recalls there were conditions attached to allowing the group in the church. These included moving as a group, refraining from individual actions, having a

leader (staff) accompany them all times, and even the senior pastor intervening to strictly prevent contact with other congregants.

The third dilemmatic pattern of acknowledging an individual with a prejudicial view is based on the most known, widely spread public stereotype about an individual with the diagnosis of schizophrenia: a being predisposed to be unpredictable and dangerous and therefore someone who should be separated from others for the safety of the innocent majority. SH describes his fear that an individual with schizophrenia would alternate unexpectedly and suddenly between "normal" and "abnormal" behaviors. KJ's case can serve as an example of intersectional issues between this epistemic view and gender as he discloses that he was also more sensitive, careful, and less proactive in engaging with the newcomers due to their gender difference:

> KJ: I would have been a little more comfortable approaching her if she were male. However, because she was female, I was cautious. Even though she was older than me, I still felt somewhat distant. In my heart, though, I wanted to help her a lot.

JH states that being exposed to the media's portrait of volatile, violent schizophrenia patients had stirred anxiety and fear in her community members, as they simultaneously underwent the tensions and conflicts that arose between them:

> JH: I'm really sorry to say this, but I think there is a strong, negative image of people with schizophrenia as potential murderers in Korean society. My community members believed that, expressing fear and concern, thinking, "What if they go mad suddenly?" This perception is reinforced by the media, which makes a big deal about crimes [committed by people with schizophrenia], contributing to the strong ingraining of these images in their minds.

Pastors also compared dealing with an individual with schizophrenia with other groups with disabilities or illnesses, either positively or negatively. While positive evaluations may be helpful, the generalization reduces room for acknowledging individual distinctiveness in people's lived experiences of schizophrenia. SH finds it easier to provide pastoral care for a person with a physical disability than for those with schizophrenia or mental illnesses:

> SH: I think it's definitely a very challenging matter. If they're physically disabled, obviously that's something I can easily address. I can push their wheelchair and create a special seat or spot for them. That's something I can easily handle. But when it comes to mental illness, I think it's a very difficult thing [in the Korean church].

On the other hand, KJ and HC more positively regard interacting with people with schizophrenia, unless they are aggressive and violent, compared to those with personality disorders or addictions.

The last pattern has more layers as it entails various aspects related to schizophrenia: medical, theological, sociological, cultural, existential, and so forth. The idea that the schizophrenia experience cannot be positivized or affirmed is inherent within the perceptions of all the research participants, overtly or covertly. HL found it challenging when asked about positive outcomes and learnings he has acquired from his interactions with the individual experiencing schizophrenia. At the interviewer's request to recall and search for positive moments or lessons, HC noted that the condition of "only if I were to positively see it" preceded his positive evaluation (HC). WJ's answer, "I wish it hadn't happened to him [the soldier]," provides a more nuanced understanding of schizophrenia, which I can glimpse in the other interviewees' positive evaluations. Compared to the various benefits gained by the research participants from the interactions, only a few features of an individuals' lived experiences with

schizophrenia were positively affirmed. This included the will to recover (WJ) and devoted faith (SH, JH, HC).

7. Practical Dilemma

Finally, dilemmatic challenges stem from practical difficulties accompanying the course of pastoral care for individuals with schizophrenia, due to deficiencies in the Korean church context. The absence of prerequisites for effectively and sustainably ministering to people with mental illnesses, including schizophrenia, amplifies the perception that ministry and the church are irrelevant to those populations and vice versa. This absence hampers and thwarts ministerial efforts to accommodate and care for them within the church. The three resources that the pastors agreed are required for effective and sustainable pastoral care but are lacking in the Korean church context include 1) information, 2) interest and support, and 3) structure.

It is not uncommon to observe that both ministers and congregants are uninformed and unknowledgeable about the lived experience of schizophrenia and those who live with it in the Korean church context. Without previous contact with these individuals, and lacking relevant knowledge, pastors and/or congregations often react out of their embedded negative cultural and religious stereotypes. While none of the research participants displayed conspicuous religious stigmatic views against people's lived experience with schizophrenia, the degree of their informed knowledge before and during the contact varied. JH aptly described the perplexity her community went through due to her own and the congregation's lack of understanding of the lived experiences of church members with schizophrenia and how to respond to them. The vision of her faith community as a communal life based on shared accountability unfortunately do not align well with the needs and accommodations that individuals living with schizophrenia require, causing bafflement and strife for both the individuals themselves and others in the community:

> JH: I admit I lacked a thorough understanding of schizophrenia from various professional perspectives… The community needed a more mature approach and better structures [for them]. Unfortunately, we were inexperienced and unprepared… Even when her parents showed up, we were messily clumsy. She [the church member with schizophrenia] wasn't doing the basic stuff she was supposed to, like laundry, and her clothes, even her undies, were all over the place in the room. Nobody paid attention to and helped with that. I should've adjusted things for her, but the community was about being independent, and everyone was still figuring out how to manage themselves.

She also added that, despite believing in its value, she did not orchestrate the collaboration with other professionals—psychiatric, pharmaceutical, and counseling—to adequately respond to the change in the church members' lived experiences.

TR was the most vocal among respondents in criticizing the lack of interest and support in caring for the population in the overall Korean church. TR and SH provided different perspectives on this phenomena. TR highlighted the significance of initiatives driven by pastors—unfortunately not happening—to enlighten lay people on the religious/spiritual causes, and for care and advocacy for people with, mental illnesses. Meanwhile, SH asserted that pastors often find themselves in a precarious position, potentially facing challenges if they call the church to advance such causes if there is strong indifference or hatred towards the group within the congregation. TR also shared his disappointment that the senior pastor's decision to allow the group into the church was not followed by support or volunteering to interact with the group from the church, attributing it again to the indifferent mindset of the pastoral leadership:

> TR: I believed that healthier people in the church, starting from the senior pastor, should practice their faith by actively engaging with the little ones of Jesus. I thought that's the

> right way, but in reality, it wasn't like that… I was hoping the church would be more proactive in offering care, support, and mutual koinonia, but none of them came along enough. Of course, the issues included insufficient financial support for the group, but beyond those, the primary issue was the mindset [of the pastor]. The practical attitude mindset seemed to be lacking.

Naming the few known mega-sized churches running specialized ministries for people living with mental illnesses, or churches with tailored ministries served by those with dual vocations of minister and psychiatrist or relevant professions in South Korea, some pastors indicated the lack of a spiritual care system for the population in most Korean churches as one of significant challenges (SH, TR). JH also commented on how the experience taught her about what her community is missing in terms of structure to effectively care for and meet the needs of individuals with schizophrenia.

In terms of realistic and practical difficulties, the absence of a care system to accommodate people with schizophrenia and other mental illnesses/disabilities in almost every individual church serves as a strong rationale to necessitate and support a type of specialized ministry for people with various kinds of disabilities, including mental disabilities. Ironically, if care is narrowly understood, this argument also may sever ties with other churches unable to afford ministries exclusively assigned to this population, thus creating a significant gap between these poles.

Conclusion

The review of the different types of dilemmas illustrates their contributing factors and how interrelated and intertwined each dilemma is. In the next chapter, the accounts of the dilemmas introduced here will undergo a critical interpretive analysis process called "thinking

with theory." Initially, the following chapter will adopt the theoretical concept of "Sanism" to re-read the accounts through the adopted theoretical lens, exploring how sanist, cultural, and religious ideas in Korean society and the church are embedded in the pastors' internal, external, relational, and communal dilemmatic experiences.

Chapter 6

Thinking with Theory: Sanism

In the following two chapters, pastors' dilemmatic experiences in spiritual care/pastoral interactions with individuals with schizophrenia in the Korean church context will undergo separate critical investigational analyses with two different foci: 1) Examining the sanist ideas and issues embedded in Korean society and churches that shaped the dilemmas faced by pastors and their congregations when interacting with individuals identified as having schizophrenia; and 2) Exploring alternative options that could be made available if pastoral caregivers engaged in dialectical theological deliberations about developing spiritual care interventions for not only the individual, but also other pastoral caregivers, those around them, and the community at large. The "thinking with theory" approach is used to capture the "complexities of social life"[1] experienced by those involved in pastoral interactions with individuals living with schizophrenia in the church. Through this critical but affirmative reading, sanist and unjust influences and overlooked and less-prioritized approaches are explored. The critical analysis of the research participants' dilemma narratives assists in the formulation of a spiritual model that acknowledges the challenges and limits of embracing individuals experiencing schizophrenia in the Korean context. It simultaneously shows how pastors creatively and dialectically engage these challenges, driven by their religious/spiritual values.

Thinking with Theory

Adopting an analytical research process called "thinking with theory" was planned from the beginning, as the original research design attempted to capture and investigate the research

[1] Jackson and Mazzei, "Plugging One Text into Another," 261.

participants' positive and relational experiences with someone living with schizophrenia through spiritual care interaction. The research focus was on identifying unusual, unconventional moments of the encounters reported by the research participants, which were expected to be scrutinized through closer analysis rather than merely interpreting what had been observed and reported during the interview.

The first two interviews with HL and SH only yielded data about the interviewees' predominantly negative experiences and subsequent negative evaluations, which had not been fully reflected upon by them prior to the interviews. Although, even before conducting the interviews, I anticipated the challenges and limitations that pastoral caregivers faced and their contribution to these negatively saturated experiences and assessments, the initial analysis of this finding led me to a "threshold," where "something new happens, something different from mere themes and patterns generated by coding."[2] I initially detected the certain presumptions that substantially blocked people's positive experiences of the person with schizophrenia they met and interacted with. As I, the researcher, also sensed its presence, the search for the theory that could explain the phenomenon shared by both the researcher and the two interviewees continued. Soon, I became inclined towards Sanism, a theoretical concept regarding the realities of people with lived experience of mental distress that provided further explanation of the data. Jackson and Mazzei describe this process of thinking with theory as follows:

> The data were not centered or stabilized, but used as brief stopping points and continually transformed, and exceeded, as we used theory to turn the data into something different, and we used data to push theory to its limit.[3]

Although I had not yet commenced coding the data from the first two interviews at the moment, the reading of transcripts, research memos, and journals played a crucial role, akin to the process

[2] Jackson and Mazzei, *Thinking with Theory in Qualitative Research*, 6.
[3] Jackson and Mazzei, *Thinking with Theory in Qualitative Research*, 6.

of working within the threshold described above, in my initial attempt to grasp sanism in light of how it is told and untold in the initial data: "plugging data to theory."

Jackson and Mazzei describe the "three maneuvers" of plugging, introduced as follows: 1) disrupting the theory/practice binary by decentering each and instead showing how they *constitute or make one another*; 2) being deliberate and transparent in what analytical questions are made possible by a specific theoretical concept… and how the questions that are used to think with *emerged in the middle* of plugging in; and 3) working the same data chunks repeatedly to "deform [them], to make [them] groan and protest" with an overabundance of meaning, which in turn not only creates new knowledge but also shows the *suppleness of each when plugged in*.[4] As the presence of Sanism became more clear and real to me through the process, my analytical questions transformed to better capture unspoken, unmentioned, or intentionally hidden experiences of the pastors within the context of the sanist Korean social and cultural understanding about people with schizophrenia and other mental disabilities. This awareness led to reflecting on those whose voices are marginalized during the research, as well as in society.

Continuing the trialogue within an assemblage as a "production of knowledge" process involving "theories", "data", and "becomings", I further introduced the concept of dialectics to navigate the complex experiences I termed pastoral care dilemmas. Ultimately, I aimed to explore what renders pastoral care ineffective, impossible, unrealistic, or irrelevant for people with schizophrenia (sanism) and contemplate underappreciated, alternative approaches (dialectics). These aspects were uncharted territories in the research participants' experiences and the meanings they cultivated, as well as in my own comprehension. By connecting various subjects, sources, and processes, the thinking with theory-approach opened up a new way to

[4] Jackson and Mazzei, *Thinking with Theory in Qualitative Research*, 5.

explore the diverse, hidden dimensions of the interviewees' experiences. Simultaneously, my understanding of theoretical concepts like sanism and dialectics evolved. The innovative and unconventional nature of the "thinking-with-theory approach" is well explained in Jackson and Mazzei's description, drawing on the philosopher Gilles Deleuze and Félix Guattari's concept: "To chart this unnamed and unmapped territory is to deterritorialize data, deterritorialize theory, and deterritorialize ourselves. To deterritorialize is to resist the route that is known in the form of tracing - to data, theory, meaning, and representation."[5] The thinking-with-theory approach guides me to remain open and reflective towards exceptions and unexpected knowledge continually emerging in the trialogue between interview narratives, two theoretical concepts—Sanism and Dialectics—and myself as a researcher throughout the entire research process.

Sanism

Compared to other terms that refer to the collection of prejudicial, discriminatory views on race/ethnicity, gender, age, or class, sanism is relatively less well-known. This immediately reflects how the lived experiences of people with mental distress, including schizophrenia, are taken less seriously. As "a larger belief system," sanism creates "the systematic subjugation of people who have received 'mental health' diagnoses or treatment."[6] Sanism includes the "various forms of stigma, blatant discrimination, and a host of microaggressions" toward a psychiatric diagnosis or lived experiences labeled as mental illness.[7] Jennifer M. Poole and Jennifer Ward contribute to this definition by stating that sanism elicits and incites "arguments that Mad individuals are not fit for professional practice or, indeed, for life."[8] Poole and Ward further draw

[5] Jackson and Mazzei, *Thinking with Theory in Qualitative Research*, 12.
[6] Jennifer M. Poole et al., "Sanism, 'Mental Health', and Social Work/Education," 20.
[7] LeFrançois, Menzies, and Reaume, "Glossary of Terms," 339.
[8] Jennifer M. Poole and Jennifer Ward, "Breaking Open the Bone: Storying, Sanism, and Mad Grief," in *Mad Matters: A Critical Reader in Canadian Mad Studies*, ed. Brenda A. LeFrançois, Robert Menzies, and Geoffrey Reaume (Toronto: Canadian Scholars' Press, 2013), 96.

on the research that claims "sanism allows for a binary that separates people into a power-up group and a power-down group," each of which is assigned socioculturally constructed images of "normal, healthy, and capable" or "sick, disabled, unreliable, and, possibly, violent."[9] Allocated the latter characteristics, people with identifiable psychiatric diagnoses or history are often cast out or aside by society.

In my dissertation, I use the term "sanism" instead of the more widely used term "stigma." This choice is based on its subtle and meticulous focus on the ongoing injustices and oppressions imposed on people with lived experiences of mental illness, rather than a broader depiction of discrimination faced by the group. Despite this focus, the concept of sanism defined above still covers various aspects of the unjust, oppressive experiences individuals identified as having a mental illness face on many levels. For my research purpose, I rely on two theoretical concepts to analyze the manifestation of sanism.

The first theoretical lens I used to identify the sanist influences on the pastors' dilemmatic experiences is political theorist Iris Young's concept of "Five Faces of Oppression," combined with disability theologian Carolyn R. Thompson's descriptions and examples that are revised by reflecting on ableist injustices that people living with diverse disabilities go through in life.[10] According to Young, oppression is "a structural phenomenon characterized by cultural imperialism, marginalization, powerlessness, exploitation, and violence," as each is considered equally unique and incomparable to others.[11] Thompson further develops the definition of oppression as "a structural system of unjust constraints on certain groups of people," based on

[9] Poole and Ward, "Breaking Open the Bone," 96-97.
[10] Thompson, "Ableism," 236-40.
[11] Thompson, "Ableism," 234.

the identifiable social group identity assigned to them.[12] The abbreviated definition of each face of oppression from Thomson's chapter that I used to aid my critical reading is as follows:

> **Cultural Imperialism:** "[W]hen the dominant group's experience is understood as the norm and any behavior or appearance different from this is seen as inferior or deviant."[13]
>
> **Marginalization:** "[E]xpels whole categories of people from participating in much of the economic and cultural life of society. These people."[14]
>
> **Powerlessness:** "There are many layers of power in our society with the people at the bottom experiencing little respect, autonomy, or voice."[15]
>
> **Exploitation:** "[W]hen one group directly benefits from the circumstance or labor of another group and there is no reciprocal transfer of power."[16]
>
> **Violence:** "[I]nclude severe assault, injury, and death, but also acts of humiliation, intimidation, and ridicule. Acts of microaggression."[17]

The reading of the untold/unacknowledged dimension of the pastors' dilemma experiences yields them to be categorized as oppressive and is followed by contextualized examples in the Korean church context presented in the research participants' narratives.

Analyzing the nature of various forms of sanist oppression, I also consider different types of injustice. This includes caregiving injustice, relational injustice, epistemic injustice—testimonial and hermeneutical injustices, existential injustice, and distributive injustice. I recognize that different levels of injustice are interconnected, underlying the manifestations of oppression experienced by individuals identified with schizophrenia in the Korean church

[12] Thompson, "Ableism," 235.
[13] Thompson, "Ableism," 236.
[14] Thompson, "Ableism," 236.
[15] Thompson, "Ableism," 237.
[16] Thompson, "Ableism," 238.
[17] Thompson, "Ableism," 239.

context. These injustices also exert negative influences on the interactions between pastoral caregivers and individuals with schizophrenia. While injustices embedded in Korean society and culture are not exclusively limited to individuals with mental illness diagnoses, histories, or lived experiences, my critical investigation aims to understand how this group of people experience these injustices uniquely, influenced by their individual and contextual idiosyncrasies. I will define relevant types of injustice when they relate to the experiences analyzed below.

One finding from the interview research reveals that Korean Protestant pastors hold limited views of pastoral care duties in terms of schizophrenia as a mental disability. The pastors' limited views result from the intersection between cultural and epistemic perspectives acquired through living in Korean society and the church. Importantly, and unfortunately, these views are not unique to the pastors themselves but are shared with their congregations, communities, and society as a whole.

It is also worth highlighting that the pastors' dilemmatic or negative experiences are influenced by various factors, including the size of the congregation they oversee, the culture of their community, and the responsibilities, burdens, and boundaries they face as ministers. Additionally, the availability of resources and support and their congregations' reactions/responses to the identified individuals play a role as well.

Therefore, concluding that the pastors interviewed were solely at fault for being trapped in their dilemmatic situation or evaluating the encounters only negatively may lead to an increase of unrealistic expectations of them as church leaders. Rather than being intentionally malicious, in most cases, toward individuals with experiences of mental illness, I argue that they are simply a part of systems that sinfully recreate and perpetuate injustices. In this context, even an individual's creative, solidary, anti-sanist ideas and attitudes toward individuals with mental

disabilities may be abandoned in favor of more prevailing, sanist ideas, accompanied by peer, community, cultural, and societal pressure. Based on the conceptual grounds of how to define sanism, I developed the following two questions to use when analyzing the data:

1. What types of oppressions and underlying injustices are present in the dilemmatic challenges faced by Korean pastors, which limit their ability to provide pastoral care to individuals with schizophrenia in the church?
2. How do these oppressions and injustices contribute to the pastors' dilemmatic and negative experiences in offering spiritual care, shaping their limited perspectives on the lived experiences of schizophrenia and its relevancy to pastoral care?

Reading Dilemmas while Thinking with Sanism[18]

1. Personal Dilemma

#1: HL: I was concerned about the threat of harm to me or anyone else in the community. I mean, I'm really concerned. And especially the female pastoral team members I was working with at the time, they were uncomfortable and scared. It felt different for them compared to their male colleagues because this young guy constantly called and texted them from early morning till night. I felt like he was keeping an eye on me, and that freaked me out. Even though I'm a guy, I started worrying about what this person might do and when he might do it.

#2: JH: You're like totally in charge of their life; that weight is seriously heavy. Because if something messes up with that person, it's all on me, like it's all my fault, and I got blamed for it.

[18] Adopted from the phrase "READING-DATA-WHILE-THINKING-THE-THEORY"; Jackson and Mazzei, *Thinking with Theory in Qualitative Research*, 4.

While the cases of injustice, as the manifestation of sanism, can be more proportionately related to the experiences of those who are identified by their diagnosis or experience of schizophrenia, it can also be experienced by their caregivers. This signifies the core issues of sanism as structural and systemic. According to Thompson's contextualized examples of oppression for people with disabilities, the underlying issue in this phenomenon of the personal dilemma is marginalization. In other words, an individual's rightful access to social recovery from schizophrenia, facilitated by their social participation with the assistance of caregivers, including pastoral caregivers, is forfeited. For example, family or other professional or unprofessional caregivers of a person living with schizophrenia often receive little to no support from their community, including local organizations and governments. In terms of pastors' personal-level dilemmas, it was evident that there was an absence of any meaningful involvement or intervention from their church communities, denominations, or other public/social institutes. Pastors endured alone the distress and burdens generated by their pastoral care interactions.

The high occurrences of personal-level dilemmas were evident in contexts where there were more frequent contacts/encounters with the person, extending beyond church buildings. Additionally, evident and continuing conflict or disturbance to the pastor's personal life was caused and intensified by the individual's perceived symptom-led behaviors (HL, JH). JH's situation was slightly better, as her community initially concurred with inclusion, no matter who someone was. However, under the shared communal lifestyle of her faith community where the line between personal and communal was blurred, JH, as the only minister available, was the subject of more direct exposure to the distressing/fear-inducing/harassing remarks of individuals with different mental distresses. Meanwhile, pastors like TR and HC, who gave passionate, self-

sacrificial care to people living with schizophrenia, were not adequately compensated/supplemented/endorsed by fellow ministers, congregations, or other faith-related or non-faith groups.

Unfortunately, during these distressing and onerous interactions, narratives of pastoral caregiving were interwoven with hints of unjust neglect for the pastors. They were left unprotected, unreplenished, and burdened with too many pastoral responsibilities without the necessary information, education, or resources for assistance, collaboration, or referral. Assumed responsibilities surpassed the available resources and support required in offering spiritual care to an individual with schizophrenia. Given the close connection between the well-being of the person being cared for and their caregivers,[19] the consistent absence of care or support provided by a group or community to caregivers in the interviewees' narratives points to an injustice resulting from community and society's insufficiently recognized accountability to, and investment in, establishing comprehensive care systems for both. This drastically shifts the simplistic, dichotomous perspective on the perpetrator-and-victim relationship in the incidents; not only is the person with schizophrenia causing interference/harm to pastors, but the perpetrator is also a victim of an unjust society that does not adequately arrange the system of care for them, including not aiding their caregivers.

Therefore, this ultimately calls for reconsidering and promoting various levels of communal accountability for cared for individuals with schizophrenia and pastors providing care to them. In the four cases mentioned above, the communities' lack of awareness of their care responsibilities is evidenced by the absence of actions by the church community and/or upper-level organizations, such as districts or denominations, to protect or assist the pastors. This, in

[19] For examples, Kittay, *Love's Labor*; Kittay, *Learning from My Daughter*.

turn, led pastors to respond to the care situations or crises at their own discretion, thus marginalizing both parties.

2. Pastoral Dilemma

> **#1: SH:** To be blunt, there is none the church can do for them [people with schizophrenia].
>
> **#2: WJ:** I purposely avoided having a pastor and a believer relationship. I told him [soldier], "You come to church and assist me, but you're doing this for your healing and recovery. That's the number one purpose."
>
> **#3: HC:** Even for you [Minhwan], I find it a little unusual when someone gets interested in this [subject]; that's why I'm agreeing to do this interview.
>
> **Minhwan:** (Smiles) Yes, I really appreciate it.
>
> **HC:** No, no, I mean, it's very extraordinary. I think you should've studied psychiatry instead.
>
> **Minhwan:** (Laughs) I've heard that a lot.
>
> **HC:** For sure. Wouldn't it be that you could help people [living with schizophrenia] a lot more with medicine?

The excerpt from the conversation with HC acutely reflects the underlying sanist idea that pastoral care is irrelevant or ineffective in regard to individuals with schizophrenia; instead medically treating their "psychiatric symptoms" is prioritized and considered what predominantly determines their quality of life. This restricted view of individuals with schizophrenia caused the pastors interviewed either to withdraw or limit their caregiving (HL, SH) or proactively to engage in, and prioritize, the arrangement of various care options outside of pastoral care without fully acknowledging implications of doing so (WJ, HC). Regardless of

their orientation, these behaviors connote that it is not the pastors' or church's chief duty or work to provide care to individuals with schizophrenia.

This can be seen a case of "cultural imperialism" of the oppression imposed on people with psychiatric diagnoses by reducing and essentializing their lived experiences of mental distress to pathologizing and psychiatric concepts and descriptions. This reductionism/essentialism narrows the opportunities for individuals living mental distress. This form of oppression is also manifested through a sense of "powerlessness" among people with schizophrenic symptoms and their caregivers. Identifying and equating individuals with their diagnosis reduces their agency over the diverse dimensions of their everyday life, with or without the presence of their "symptoms."

The limited views embedded in pastors' responses underscore a noteworthy and contradictory phenomenon: individuals with mental illnesses, including schizophrenia, demonstrate a strong interest in religious or spiritual experiences.[20] This inconsistency implies a significant gap between the perspectives of pastoral caregivers and those with lived experiences of schizophrenia concerning the roles of religion and spirituality in embracing and spiritually leading individuals with schizophrenia in the church. This does not imply that all religious or spiritual experiences are guaranteed to be conducive and beneficial to individuals who seek them, but it still meaningfully reflects the unmet needs of people in the midst of their mental distress.

[20] Huguelet et al. "Spirituality and religious practices," 368-71.

The epistemic injustice behind this type of dilemmatic experience is testimonial injustice. Drawing on the explanation of the founder of the term, British philosopher Miranda Fricker, the philosopher Jeremy Wanderer presents a rephrased definition of testimonial injustice:

> [Testimonial injustice] occurs when, following an act of telling someone something, a Speaker is accorded insufficient credibility by a Hearer due to a prejudicial stereotype held by the Hearer. More specifically, the Hearer subscribes, at some cognitive level and in a manner that is relatively resistant to counter-evidence, to a widely-held belief that links a salient aspect of the Speaker's social identity to a disparaging attribute, as a result of which the Hearer accords the Speaker less credibility than she deserves.[21]

I admit that the issue of testimonial injustice may not be the sole factor shaping the pastors' views regarding the scope and limits of pastoral care with people with schizophrenia; there are other factors, including the evaluation of an individual's capabilities and conditions, as well as practical, relational, or ethical considerations that hinder pastoral caregivers' meaningful/intended interactions with individuals experiencing schizophrenia in their parish. However, the pastors' conclusions are drawn from their assessments of the individuals encountered as incommunicable and uncredible and their remarks and behaviors as "symptoms," rather than being based on careful listening to, and affirmation of, the accounts of those individuals. In this regard, my dissertation has a limitation in not including the accounts of those with lived experience of schizophrenia, specifically concerning how they comprehend and affirm the significance of religious/spiritual experiences and activities. Nevertheless, reading the narratives through the lens of sanism helps capture that, rooted in testimonial injustice, pastors do not intend to listen to the voices of those unheard.

In fact, the presence of testimonial injustice beneath the pastors' neglecting areas outside of the medical or pathological experiences of the people's lives calls for a more drastic shift of

[21] Jeremy Wanderer, "Varieties of Testimonial Injustice," in *The Routledge Handbook of Epistemic Injustice*, ed. Ian James Kidd, José Medina, and Gaile Pohlhaus (London; New York: Routledge, 2017), 28.

perspective: it is pastors' and the church's responsibility to care for those experiencing mental illness. For example, the social and cultural suffering of people with mental distress is not minimal or auxiliary to those defined by psychiatry as characteristic experiences of schizophrenia.[22] The spiritual dimension of social suffering calls for spiritual intervention that aids in the recovery and empowerment of those psychiatrized people.[23] Indeed, pastoral care has much potential to rejuvenate other dimensions of the lives of people living with schizophrenia. With this shift of perspective, fostering genuine collaboration with other professionals in care of people with schizophrenia can help break the mold of binary thinking on the relevance of pastoral care.

3. Relational Dilemma

> **#1: HL:** So, looking back and criticizing my decision at that time, I think I didn't really feel for this patient. Like, I wasn't aiming to help him to be treated, didn't have the drive to get him back to living a more regular, normal life. My focus was entirely on keeping the community safe and stable. I guess I couldn't care much for him as an individual soul.
>
> **#2: SH:** Well, first of all, I think there's an idea of the church's ideal lay leaders, and he just didn't fit into that. No one thought it was weird that he wasn't selected, other than himself and his mother.

Arising out of the relational tension between two or more groups, pastors caught in this type of dilemma found themselves being forced to choose or lean towards one group over others. The relational injustice underpinning this dilemma is present in the ways people with disabilities are treated less favorably or significantly by the pastors or their congregation, particularly in

[22] See Kathleen J. Greider, *Much Madness Is Divinest Sense: Wisdom in Memoirs of Soul-Suffering* (Cleveland: Pilgrim Press, 2007), 67-96; LeFrançois, Menzies, and Reaume, eds., *Mad Matters*; Beresford and Russo, eds., *The Routledge International Handbook of Mad Studies*.

[23] Tenney, "Spirituality, Psychiatry, and Mad Studies," 290-92.

terms of meeting their needs for maintaining a faith life in the church. The spiritual needs and wants of individuals with disabilities life are overlooked or considered "special," devalued, and less prioritized compared to the "normal" needs and wants of ordinary people in the faith community.[24] Instances of relational-level injustice can be observed in the narratives where the faith community unequivocally made decisions about the treatment of individuals with schizophrenia, favoring the opinions and needs of the majority and disregarding those of the individual resisting the decision. These decisions were justified by statements that prioritizing the majority's safety or satisfaction is best for the overall health and growth of the community. (HL, SH).

The oppressions imposed on church members with schizophrenia, based on Young's categorization, include marginalization, as they were deprived of the right to be treated equally or taken seriously. As a contextualized example, individuals with a disclosed history of mental distress are often excluded from meaningful participation or roles in church activities without engaging in a discussion with them in advance. In the examples discussed, the individuals experienced powerlessness and violence, as the faith community's decisions about how they should build or enjoy their faith life in the community were made "without consulting or listening to them" and "enforced" upon them, unavoidably resulting in their resistance and "voluntary" departure from the community.

To comprehend how relational injustice was insidiously pervaded and influencing in the contexts of the research participants, pastoral and practical theologian Duane Bidwell's review of the related theological discussion, which he presents in his *Empowering Couples*, provides a useful resource. In providing criterion to determine "helpful and healthful covenant partnerships"

[24] Thompson, "Ableism," 236-37.

in caring for couples, Bidwell lists three relevant theological concepts, including relational justice, "respect for embodiment" and "resistance to colonization."[25] Bidwell summarizes pastoral theologian Larry Kent Graham's understanding of relational justice as pursuing "shared power, shared opportunity, and shared rewards among all people."[26] Bidwell offers an applied definition of relational justice as a guiding principle for the covenant partnership that aims to "not favor one person over another but functions as a true partnership that equally benefits (and allocates equal responsibilities to) each partner."[27]

While Bidwell's comprehensive discussion on mutuality in his book avoids pitfalls, in the presented definition of relational justice alone, the emphasis on not favoring and equal responsibilities might be mistakenly applied against people with mental distress. This could be based on their perceived lack of contributions, calculated by ableist, sanist standards, or charitable preferences. The narratives of HC and TR, where pastors actively take sides with individuals or groups of people with psychiatric diagnoses, may be falsely accused of being examples of breaking the principle of relational justice. Thus, it must be clearly stressed here that relational justice does not equate to pursuing literal, uncontextualized equality among all. This also deeply resonates with liberation theology's well-known concept of "God's preferential option for the poor."[28]

In line with this argument, relational justice can be approached as the collaborative efforts of all involved to create balance through "mutual empowerment." as Bidwell sharply

[25] Duane R. Bidwell, *Empowering Couples: A Narrative Approach to Spiritual Care*, Creative Pastoral Care & Counseling (Minneapolis: Fortress Press), 21, Kindle.
[26] Bidwell, *Empowering Couples*, 21, Kindle.
[27] Bidwell, *Empowering Couples*, 21, Kindle.
[28] Swinton, *Resurrecting the Person*, 13-14.

discerns: “Because partners bring unequal gifts and strengths to a relationship, equality is impossible; thus, the goal of mutual empowerment is mutuality or right relationship.”[29]

Addressing relational injustice is at the core of learning how to live together in a faith community. It must consider the condition of each individual and other contextual factors to be sustainable and mutually beneficial. For this task, Bidwell’s concept of partnership offers a brilliant insight: “Resisting colonization”[30] reminds us of the unheeded task of pastoral caregivers and the church to “[work] as a team to keep their psyches (and their relationship) from being colonized by constraining or harmful cultural beliefs.” His proposal for the partnership can be expanded to the faith community relationship in terms of relational justice.[31]

4. Theological Dilemma

> **#1: Minhwan:** What did having him around mean for the church as a faith community?
>
> **HC:** Well, he’s just a patient. He’s a mentally ill patient, and the pastor and his family are looking after him. That’s basically his location in the church. That’s all there is to it. The folks from the village or other church members didn’t really bother or care about him much.
>
> **#2: Minhwan:** Is that [another incident with a parish member whom the pastor suspected as a case of schizophrenia][32] what you were talking about earlier—mixed forms [of mental illnesses and spiritual problems], mixed causes?

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[29] Bidwell, *Empowering Couples*, 23. Kindle.
[30] Bidwell, *Empowering Couples*, 24. Kindle.
[31] Bidwell, *Empowering Couples*, 24. Kindle.
[32] The case was shared by the interviewee; however, at the researcher’s discretion, it was not primarily addressed in the previous chapters. The research participant was called upon by the neighbor of his church member for displaying demon-possessed-like behaviors. Upon arrival at the parishioner’s home, the pastor discovered the person was naked, kneeling, and begging for his sins to be forgiven. The pastor returned with other co-pastors and found out the person went to the closet, holding his deceased mother’s framed picture, and kept saying he was sorry

WJ: Yes, I think it was a mix. I think there were some spiritual issues as well. I can't say how much [the spiritual influence] was there to some extent. When I asked him, "Why do you say you did something wrong?", "What's bothering you?" while holding him to be still [from being agitated], and he said he did it wrong to his mother.

What commonly emerged in interviewed pastors' theological struggles was their difficulty in defining either the theological nature or spiritual cause of someone's experience with schizophrenia and, consequently, how to address it theologically. This difficulty is rooted in their approach to understanding others' experience: the attempt to comprehend the lived experiences of individuals "from where they (the pastors) stand." I use this expression figuratively for two reasons. Pastors theologically interpret someone's lived experiences of schizophrenia by observing, interacting with, and being affected by them. They also perceive these experiences through the lens of their embedded theology of schizophrenia. Given that perceptions and interpretations of others are inevitably influenced by our own biases, beliefs, and values, the pastors' understanding was inherently constrained to their own theological epistemic location. This human limitation illuminates issues of epistemic injustice, including testimonial injustice and hermeneutical injustice, deeply embedded and undergirding the pastors' dilemmatic struggles; simultaneously, however, it suggests an alternative strategy to move closer to where others stand.

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for what he had done. The pastor interrogated the person through a deliverance ritual by praying, reading scripture, singing hymns, and ordering the demon to leave. The person kept begging for forgiveness, saying that he had done many wrongs, including to his mother, without revealing any specific details. The person was calmed down by the ministerial team shortly after, and his behaviors remained and stopped a few days later. While the research participant was aware of the parish member's addiction to alcohol before this encounter, he later also learned that the person was a sex offender and had spent time in prison. I do not include this experience in my analysis, except for its implications for theological dilemmas, as I rule out the possibility of a schizophrenia-spectrum experience due to the individual being undiagnosed, having a history of severe alcohol addiction, and its brevity. However, I refrain from making a diagnosis or assessment of the case.

With the definition of testimonial injustice already presented in the pastoral dilemma section of this chapter, I will provide a brief introduction to hermeneutical injustice. Fricker defines hermeneutic injustice as "the injustice of having some significant area of one's social experience obscured from collective understanding owing to a structural identity prejudice in the collective hermeneutical resource."[33] Drawing on the Fricker's formulation of the concept, philosopher José Medina further explains the phenomenon as follows:

> Hermeneutical injustice is the phenomenon that occurs when the intelligibility of [communicators] is unfairly constrained or undermined, when their meaning-making capacities encounter unfair obstacles, or, as Fricker puts it, "when a gap in collective interpretive resources puts [someone] at an unfair advantage when it comes to making sense of their social experience" (2007: 1).[34]

In other words, hermeneutical injustice occurs when, instead of validating and affirming one's own descriptions of lived experiences and identity as accurate and authentic, socioculturally maintained stereotyped understandings that are attached to identifiable social markers are forcefully imposed upon the person or group to describe their experiences. The two different types of epistemic injustice prevented pastors from engaging with the church member's theological/religious narratives, thus eventually leading them to use their limited embedded theology as the grounds from which to understand schizophrenia as human experience.

Applied to the critical reading of the pastors' narratives of pastoral care dilemmas from a theological perspective, testimonial injustice happens when they invalidated expressions of faith by church members with schizophrenia, which was the case in some—but not all—cases. Reading the pastors' stories with the awareness of the injustices and oppressions experienced by people with psychiatric diagnoses, I have noted that most of the pastors' positive evaluations of

[33] Miranda Fricker, *Epistemic Injustice: Power and the Ethics of Knowing* (Oxford: Oxford University Press, 2007). 155.

[34] José Medina, "Varieties of Hermeneutical Injustice," in *The Routledge Handbook of Epistemic Injustice*, ed. Ian James Kidd, José Medina, and Gaile Pohlhaus (London; New York: Routledge, 2017), 41.

caregiving interactions with an individual with schizophrenia, especially related to the individual's faith, are from their simple mentions of the individual's active participation in church, devoted behaviors, or respectful attitudes in their faith lives (SH, HC, KJ), except for the brief mentions about the individuals' testimony shown in KJ and JH.[35] On the flip side, examples where pastors devalued the expression of the individual's faith included, for example, SH. In his interview, SH reported that he initially regarded the person's conspicuous behaviors of standing up and moving around the sanctuary during praise and worship as fervent, spirit-driven actions—acceptable in the Pentecostal-natured Korean church culture. However, when he learned about the person's diagnosis, he later attributed these behaviors to pathology.

The absence of accounts covering the faith lives of church members with schizophrenia is a limitation of this analytical reading and my dissertation. However, the absence of additional observations and reflections from the pastors regarding the faith of their church members with schizophrenia, as well as its significance and implications for them, still implies the occurrences of testimonial injustice by being, in a way, also a form (via omission) of discrediting the individuals' faith experiences and expressions. I continue to be intrigued about what motivated the individuals in HL's and KJ's narratives to wander among different churches, even when consistently encountering continuous rejection.

Hermeneutical injustice is observed in the pastors' narrative accounts through their failure to identify any opportunity to theologically affirm individuals' experiences with schizophrenia. All research participants explicitly or implicitly refused the judgmental and punitive theological perspectives on schizophrenia that place blame on its experiencers or their families/relatives. Intriguingly, their narratives overtly or tacitly dismiss the possibility of

[35] These remarks of the church members will be discussed in the conclusion chapter.

positive aspects within the lived experiences of individuals with schizophrenia, including the theological dimension. This implies that the pastors assume, for those living with schizophrenia, that none of the experiences are considered meaningful or beneficial. This is evident in the interviewees' silence on related evaluations of knowing and interacting with these individuals. For instance, despite being the most vocal in condemning the judgmental, traditional theological concepts of schizophrenia, KJ does not articulate an alternative theological or religious construct about schizophrenia that could be helpful in highlighting positive aspects of people's experiences. Interpreting the silence amid myriad possible explanations, one conclusion becomes undoubtedly clear to me: without considering the perspectives of those with lived experiences, the endeavor to cultivate or discover meaning—especially positive religious/spiritual meaning—is infeasible. Accordingly, this supports the presence of epistemic injustices entrenched in theology and practice in the Korean church contexts.

The attitudes of pastors towards the phenomenon of demon possession can be seen as an extension of the discussion of epistemic injustice undergirding this theological dilemma. For pastors, affirming the possibility of a correlation between spiritual problems and demon possession creates a peculiar, obscure juxtaposition with their unequivocal denial of demon possession's relationship with schizophrenia. As demonstrated in the initial descriptions of WJ in this section, this peculiar coexistence sometimes leads to a resurgence of suspicion regarding the moral or spiritual condition of individuals experiencing mental illness. Aware of the long history of suspicion and judgment toward people's experiences of mental distress in both Korean traditional culture and Christianity, I propose applying the same principle as a prerequisite for pastoral care: Exploring one's spiritual journey with either demon possession or schizophrenia deserves and necessitates self-exploration around meaning-making and decision-making, as well

as the retrieval of one's true identity, both in recovery and daily life. Listening to an individual's religious/spiritual experiences and guiding them in the construction/reconstruction of religious/spiritual meanings from the various dimensions of their lived experiences of schizophrenia can serve as a pathway in this journey.

Cultural imperialism is the most obvious instance of oppression evident in the pastors' theological dilemmas, aligning with the nature of epistemic injustices embedded in Korean church culture. Its manifestation in the narratives of the research participants is more about rendering faith, religion, or spirituality irrelevant or insignificant to individuals with schizophrenia rather than ascribing negative religious or spiritual depictions to the individuals, as traditional Christian theology often did.

An example reflecting this dilemma is that pastors or other church members often perceive and treat these individuals solely as patients. A more intensified and severe manifestation of this issue can be seen in the exploitation of, or violence directed towards, individuals with mental disabilities, including schizophrenia, who are unwantedly perceived as passive recipients of the church's and believers' care. They are objectified for the sake of hospitality and charity. For example, religious education or sermons which teach that people with mental disabilities exist for God's glory or as opportunities for others to practice God's love contribute to the perpetuation of sanist ideologies around mental illness.

5. Ethical Dilemma

> **#1: KJ:** If God sent her to us, He would want our church to become a close-knit faith community of mature believers. I had been preparing for that because, as time went on, more people were expected to leave—most of the church members.

#2: HL: It was a realistic and valid excuse. I kept convincing myself he [the person] needed to be removed [from the church community] to keep the other young people safe. We got to do it for the good of the community. It had to be done [for the community].

#3: TR: Initially, the senior pastor set a condition: they could come to the church as a group and would be welcomed, but they had to maintain discipline within the church. They were expected to follow orders during worship. I believe that's what [the senior pastor] emphasized – the importance of moving as a group. Consequently, there always had to be a leader, and I think he restricted their contact with the congregation.

The dilemmas within the research participants' pastoral encounter narratives overlap and intersect. Similarly, the ethical dilemma of inclusion or exclusion of persons living with schizophrenia is overarching and relates to other dilemmatic challenges. The offer or denial of inclusion is an existential dilemma for those assigned and circumscribed by Korean sociocultural norms and values as having a psychiatric illness. Beyond just belonging, this is ultimately an issue of justice and their right to existence in Korean society and the church.

Pastors facing an ethical dilemma perceive the existence of those displaying discomforting behaviors associated with schizophrenia as causing a dire conflict with other sane church members without the lived experience and consider it incompatible with their faith lives (HL, KJ), although the severities of the individual's behaviors that influenced the church's decision to include (KJ) or exclude (HL) them were greater in KJ's case than in HL's. While the churches where SH and TR served as associate pastors did not outwardly display an exclusionary attitude towards the individual or the group of people with schizophrenia, they covertly controlled and constrained each individual's activities in the church through additional

conditions, rules or bylaws. These were either not applied (TR) or applied leniently (SH) to others to facilitate and grow the faith lives of the congregations.

That the way individuals without mental distress maintain their faith life in the church becomes an exemplary model of Christian faith life – defining what is considered "typical" or "normal" for a church – is a manifestation of cultural imperialism. Marginalization becomes evident in the ethical dilemmatic experiences that compel people to adhere to rules and standards or more strictly apply them to "atypical" members of the faith community, perpetually excluding them under the scrutiny of suspicion. Take, for example, TR's experience, where the group from the psychiatric transitional care shelter attending worship services was told they could only move as a group in the church building. This attempt to exert control and the microaggressions it included—directed at both the individuals and the group as a whole—are a form of violence.

Being aware of the existential, ethical injustice dealt by the individuals recognized with their schizophrenia experience, I also acknowledge the tension present between embracing individuals with schizophrenia and the genuine concerns, disturbances, and damage people can receive from the verbal, emotional, and behavioral expressions of a person whose experiences are described as schizophrenia. I admit the conditions of some people living with schizophrenia make it difficult or even impossible for them to share life with others in a faith community directly. Despite this, they should still be allowed to be part of the community and provided with adequate care. Addressing this justice issue from theological perspectives, many theologians argue and advocate for the faith community as a space where people with and without different types of disabilities can coexist, supported by various theological reasoning.[36] However, I

[36] See Reynolds, *Vulnerable Communion*; Barton, *Becoming the Baptized Body*; Swinton, *Becoming Friends of Time*; Amy Kenny, *My Body Is Not a Prayer Request: Disability Justice in the Church* (Grand Rapids, Michigan: Brazos Press, a division of Baker Publishing Group, 2022).

acknowledge it may be more challenging when it comes to schizophrenia as a mental disability. This is because the behaviors of specific individuals in this group may pose risks and dangers to others. However, it is crucial to emphasize that this fact should not serve as grounds to exclude everyone diagnosed with schizophrenia because every case is different.

Reviewing the injustice embedded in the ethical dilemma of inclusion and acknowledging realistic limitations brings to light two important tasks in addressing ethical issues in the context of pastoring and caring for people with mental disabilities, including schizophrenia, in the Korean church. There is a need to reexamine and reconstruct the understanding of faith life in light of the lived experiences of schizophrenia and other mental disabilities. This reevaluation is meaningful to those living with these experiences and those who have not yet had significant contact with these individuals in discerning the overlapping essence and meaning of seeking faith/spirituality across diverse contexts. Consequently, this reexamination can contribute to remodeling the faith community's life, fostering a more inclusive environment.

Additionally, there is an opportunity to challenge binary thinking on inclusion by recognizing that connections can be built and maintained in various ways. It prompts questions about how to broaden our narrowed understanding of inclusive faith. As an act of faith, regardless of their participation in the church, what if the church provided caring attention to individuals experiencing schizophrenia, particularly in collaboration with connection with communities of people with lived experience of diverse mental distress, their families and relatives, and those pursuing just treatment for this group outside the church? What if the faith community, not pastors alone, were willing to address the isolation and marginalization of individuals with schizophrenia by reaching out and sharing their lives and sacred space?

Considering the rise of peer support movements and support groups globally,[37] what if the church redefined its mission to actively endorse and collaborate with, not co-opt, these groups and learn from their expertise and experience? What if our "faith life" was not limited to narrow geography and an exclusively communal, collective identity solely based on the same signifiers?

6. Cultural-Epistemic Dilemma

> **#1. KJ:** I've told the congregation many times that we're all disabled; we're people with a more serious sin of the heart, a sinful heart. So, the visible disability is a small matter, and conditions like schizophrenia are minor sins or abnormalities compared to the wickedness of our hearts. Don't say that they're the only disabled people; we're all disabled people, and we're all the same.
>
> **#2. TR:** So, they're actually the main characters [in society], but they're the ones going through some social struggles, even though they're the ones who are supposed to be welcomed.
>
> **#3. HC:** Mr. [omitted], our Mr. [omitted] probably went to heaven because he couldn't sin. Couldn't.
>
> **Minhwan:** He couldn't commit sin?
>
> **HC:** No. And he believed in Jesus, even though it's important to believe in Jesus and confess with a clear awareness [and he couldn't do those). But anyway... I think he knew something. While other people in the church were dozing, he didn't; he sat and listened during the worship.

[37] See Russo and Sweeney eds., *Searching for a Rose Garden*; LeFrançois, Menzies, and Reaume, eds., *Mad Matters*; Isla Parker, Joachim Schnackenberg, and Mark Hopfenbeck, eds., *The Practical Handbook of Hearing Voices: Therapeutic and Creative Approaches* (Monmouth: PCCS Books, 2021); Paek, *Yŏgi uri ka itta*.

The cultural-epistemic dilemmas research participants face contain underlying issues related to epistemic injustice. Long-held, socioculturally constructed stereotypes of people with schizophrenia challenge two realities of those with lived experience of schizophrenia in the church. First, the person is a legitimate faith community member with valid religious/spiritual experiences and equally deserves pastoral care like other members. Second, the person is a human being with their own distinct subjective experiences of schizophrenia, and their experiences are not limited to, and do not necessarily fit into, one monolithic psychiatric description of schizophrenia. Imposing stereotypical, stigmatizing views associated with schizophrenia in Korean society without attempting to listen to and understand a person's subjective experiences creates injustice, leading to misunderstanding and misrepresentation. This, in turn, deprives them of their rights to be recognized and treated justly, or even to exist in the church. The pastors' cultural-epistemic dilemma narratives show that epistemic injustice can happen in various locations in the church, including during interactions with pastors, lay members, and the community. It frequently occurs, even when there are good intentions toward the person or the group identified with schizophrenia. This caught my attention and will be discussed in this section here.

The issues of epistemic injustice, and specifically hermeneutical injustice, arise regardless of each individual's actual subjective, distinctive experiences and contexts under the label of schizophrenia. Like negative social prejudices associated with schizophrenia, some participants hint at a benevolent but condescending view of the person's lived experiences. For example, KJ averred that we are all disabled when sharing with his congregation his theological argument for defending and promoting the care of the church members who display aggressive, disturbing behaviors. Belying his intention by declaring its relevance to everyone, KJ

inadvertently diminished the gravity and reality of living with disabilities. While his words can be considered theological/symbolical, his position—and the authority he holds with it—means his words risk creating another unjust hermeneutical explanation that falsely misrepresents experiences of disability.

Another example of benevolent epistemic injustice directed towards individuals experiencing schizophrenia is HC's theological statement about the improbability of a person with schizophrenia committing sins. Here, a hermeneutical injustice is present through the attempt to elevate the spiritual, sin-free status of the individual. Pastoral theologian K. Samuel Lee brilliantly identifies the problems with this type of theological assertion by criticizing the question, "Is the salvation of those with intellectual disabilities possible?"[38] Lee points out that the embedded theology that underlies this question is a limited, judgmental, fear- and shame-driven theology because it is built without an informed knowledge of disabilities.[39] Lee concludes that the question is not only irrelevant but also unhelpful in transforming the environment of the church into one that genuinely includes and cares for people with disabilities.[40] In light of this argument, unfortunately, HC's approach may serve to further the exclusion of people with disabilities.

A more commonly observed view, yet one with a similar nature, is the perception of persons with schizophrenia as patients (HC, KJ). TR showcases this with his juxtaposition of a patient and "the little one" deserving hospitality when describing the individual with schizophrenia he was engaging with, without mentioning which identity was primary in their relationship. Representing those with lived experiences of schizophrenia as recipients of

[38] Kyungsig Samuel Lee, "Jangae-wa mokhoesangdam" [Disability and Pastoral Counseling], in *Jangaein sayeog-ui sinhaengjeok uie* [The theology of the disabled], ed. Jae-seo Lee (Seoul: Segye Milal, 2018), 248.
[39] Lee, "Jangae-wa mokhoesangdam," 248.
[40] Lee, "Jangae-wa mokhoesangdam," 251.

generous understanding and hospitality given their illness medicalizes and normalizes the behaviors or expressions that may cause disturbance, interference, or harm to others. While this view attempts to combat harmful stigma and improve the treatment of people with mental disabilities, it is not without criticism. Social work scholar Jerry Tew argues that "[promoting], as a normalizing idea, the notion that mental distress is 'an illness like any other'" circularly strengthens the otherization of those with lived experience by highlighting their "difference [from others] as biological."[41] As long as an individual with schizophrenia visibly impacts others' lives, the medicalization of schizophrenia as an anti-stigma movement cannot successfully remove the negative prejudices attached to the group with this psychiatric diagnosis.

It is worth mentioning one Korean cultural concept that plays a significant role in generating and proliferating epistemic injustice for someone living with schizophrenia in Korean society and the church: *Minpye* (Nuisance). Defined as the violation of the cultural norm of not bothering or burdening others,[42] the Korean cultural understanding of *minpye* shuns and renders unwelcome individuals identified with their diagnosis or experience of schizophrenia. This is the result of anticipated interference, inconvenience, or disturbance, along with the fear of associated dangers and risks caused by these individuals due to the visible markers of their diagnosis. This cultural construct corroborates the culture of epistemic injustice against people diagnosed or labeled with mental illness in Korea, depicting them as troublemakers and a threat to society.

The analysis of this type of dilemma has overlapped with other dilemmas as epistemic injustices are rooted in every other injustice experienced by people with lived experiences of

[41] Jerry Tew, "Towards a Socially Situated Model of Mental Distress," in *Madness, Distress and the Politics of Disablement*, ed. Helen Spandler, Jill Anderson, and Bob Sapey (Bristol: Policy Press, 2015), 72.

[42] Max S. Kim, "Seoul's radical experiment in digital contact tracing," The New Yorker, April 17, 2020, https://www.newyorker.com/news/news-desk/seouls-radical-experiment-in-digital-contact-tracing; Eun-Sung Kim and Ji-Bum Chung, "Korean Mothers' Morality in the Wake of COVID-19 Contact-Tracing Surveillance," *Social Science & Medicine* 270 (February 2021): 113673, https://doi.org/10.1016/j.socscimed.2021.113673.

schizophrenia. Due to its nature as a form of violence, epistemic violence may forcefully impose on others, even in their approach to treating and providing care for individuals with schizophrenia, regardless of intention.

The suggestion for how to address this issue is also like those mentioned in the other dilemmas: seeking to validate and affirm the rights of individuals with schizophrenia and authentically attempting to learn the history of the individual by listening to their lived experiences. Doing so allows for the retrieval of their self and spiritual identities. I further suggest that this does not need to be achieved by one path; working with peer specialists, groups, organizations, and other professionals maintaining mad-positive and affirming approaches (examples will be listed as Appendix D) should be encouraged. Through collaboration, pastoral caregivers and the church can diversify their ways to connect and include those with schizophrenia.

7. Practical Dilemma

> **#1: SH:** I think it's very difficult for the church to establish a system for accommodating the needs of minorities. It takes a lot of determination [on the church's part] to create such a system customized for minorities… [And if there's no one volunteering to do it,] it ends up becoming additional work for pastoral staff. Associate pastors and staff end up undertaking it, so... it is challenging to invest and create systems for minorities in the church.
>
> **#2: TR:** The challenges I personally remember—firstly, it was disappointing that the church didn't provide enough support for them [the group from a transitional shelter for former psychiatric inmates], both in terms of time and financially. There was also a lack of interaction with other members and overall hospitality from the community. Sure,

there were some [superficially] hospitable gestures, but they needed deeper connections, which was very rare. I wished the lay members could understand better, show empathy, and get involved in care more, but it didn't happen because of the [emotional] distance.

Regarding the more realistic challenges arising from the practice of pastoral care in the discussed contexts of interviewee's narratives, the practical dilemma highlights the issue of distributive injustice as a primary underlying cause. In the discussion of disability and justice summarized in the *Stanford Encyclopedia of Philosophy*, distributive injustice is defined as "the injustice of... outcomes in which there is an inequality of income, wealth, health, or other aspects of well-being resulting from morally irrelevant factors."[43] The argument emphasizes that, in the context of disability justices issues, distributive injustice is deeply intertwined with relational injustice which indicates, "the injustice of certain forms of treatment—in particular, the treatment of some people as moral, social, or political inferiors on the basis of morally irrelevant characteristics."[44] This is due to their mutual influence on one another in creating and sustaining the maltreatment of people with disabilities socioculturally, morally, and materialistically.[45] Therefore, the remedy for both relational and distributive injustice inevitably calls for addressing the issues related to them concurrently, given their discrimination or unfair treatment based on them are more significant than other minority groups.[46]

Pastors' accounts of practical dilemmas caused by the absence of well-orchestrated care systems, information, and resources, or a lack of congregation's support or interest in the individual or group of people living with schizophrenia (SH, TR, JH) prove that the systems in the church—and those in Korean society as well—have been built "for average or typical

[43] Putnam, "Disability and Justice."
[44] Putnam, "Disability and Justice."
[45] Putnam, "Disability and Justice."
[46] Putnam, "Disability and Justice."

members."[47] As a result, the presence of those whose ways of mentally expressing themselves differ from the majority is perceived as unfit for the system, creating barriers that impede interaction between the two groups.

The oppression of—and lack of resources provided to—individuals with schizophrenia is a form of marginalization. Living in a community that, intentionally or not, lacks spiritual care for individuals with lived experiences of mental illness—such as an organized structure that provides training to volunteer caregivers and the community, emotional or relational support, referrals to other professionals, or peer support resources—signifies the organization's lack of initiative and orientation toward distributive justice. Such inaction makes them feel powerless and doubt their full membership and equal regard in the congregation.

Exploring how to fight against distributive injustice, it is worth noting that the pastors interviewed acknowledged the limitations of their pastoral care contexts by comparing them to well-organized and supported specialized ministries run by mega-churches (SH, TR). The limited thinking of "have it all or not at all" can be overcome by actively searching for and organizing collaboration and networking with groups of people with lived experiences of mental illness, peer support specialists, and other professionals. This collaborative effort educates the congregation and facilitates the harmonious coexistence of all parties involved.

[47] Putnam, "Disability and Justice."

Chapter 7

Thinking with Dialectics

Dialectics

Disclosing the injustice prevailing in the pastors' caregiving dilemmas with individuals with schizophrenia cannot exhaustively resolve the dilemmas, as those dilemmas still require something that catalyzes leverage/breakthrough moments from these challenging situations. I now turn from critical reading of the unspoken—but loudly existing with their presence—voices of the pastoral caregivers and care receivers in that specific spiritual caregiving context to aiming to discover unfulfilled, unconventional possibilities.

Dialectics, or the dialectical thinking approach, primarily drawn from Dialectical Behavior Therapy in this dissertation but also tracing its roots in the long history of various philosophical traditions,[1] is the principle to acknowledge the contradicting truths residing in every experience or phenomenon. Instead of leaning toward either, it involves making a balance in between to validate both as a "middle-path."[2]

A critical reading of the pastoral care dilemmas and negative experiences of the research participants through the lens of dialectical thinking sheds light on the neglected, underappreciated choices and untapped values as antitheses, opposing the selected choices and values undergirding them as theses. The dialectical approach does not stop at recognizing and affirming the presence of these two valid opposites; further, it attempts to introduce a synthesis, a balanced approach to tap into both possibilities and achieve the values entailed.

[1] Veraksa, Basseches, and Brandão, "Dialectical Thinking," 3.
[2] Linehan, *Cognitive-Behavioral Treatment,* 109-10.

The application of this approach in re-reading the pastors' narrative proceeds in the following order. Focused on, but not limited to, the accounts about dilemmatic, negative, or limited experiences in respective pastoral encounters with the church member living with schizophrenia, these are read with two sets of analytic questions.

1) How did the pastors' upheld beliefs and values impact their decisions when providing spiritual care to a person with schizophrenia in challenging, dilemmatic situations? What beliefs and values are neglected or undervalued when deciding how to care for people with lived experience of schizophrenia, especially when they face limitations or dilemmas?
2) What would be the middle path/synthesis to affirm and touch onto those contradicting values? What is the core value that undergirds it?

I identify pastors' stances and choices made in their pastoring/caring interactions with the person and create a summarizing statement called a "thesis." To refer to the values applicable to their beliefs, practices conducted, and each summary statement, I draw on the list of values and their brief descriptions titled Personal Values Card Sort, authored by William R. Miller, Janet C'de Baca, Daniel B. Matthews, & Paula L. Wilbourne from the University of New Mexico Department of Psychology. (included as Appendix C.) I select up to three values that match the core value or the main idea of the statement.

Based on the recognition of the thesis, continuing the reading of the narrative aims to capture the interviewee's unfulfilled, given-up choices, or values sublimated due to various limits or concerns, whether mentioned or merely hinted at. I create a statement of these, which is later named "antithesis," and assign the relevant values from the list above. Both thesis and

antithesis are conjured up, reflecting the commonality among different sub-dilemmas located under the same category.

Several dialectical behavior therapy (DBT) strategies and instructions have been adapted to guide my critical reading in generating thesis and antithesis statements from the dilemma narratives.[3] Exercise statements that demonstrate the application of dialectics to clinical cases in the chapter of Boritz et al.'s *Deliberate Practice in Dialectical Behavior Therapy* are particularly useful. The following are exercise examples that demonstrate how I construct statements for each dilemma:

#1: Client: "[Irritated] I'm trying so hard. I don't think you understand how hard it is. Some days I just don't feel like working so hard."

Therapist: "You are doing your best, and you need to try harder;"

#2: Client: "[Sad] I want to leave my job, but I don't want to disappoint my boss. He's been really supportive. I feel like if I leave, I'm going to let him down."

Therapist: "You care about your boss, and you don't want to continue in the job."

Finally, with the review of the identified thesis and antithesis statements for each dilemma, I formulate a synthesis statement that acknowledges the values and limitations of each decision. This process is assisted by scrutinizing the values list to find one or two at the core of what the synthetic statement aims to convey.

[3] Linehan, *Cognitive-Behavioral Treatment*, 205-19; Linehan, *DBT Skills Training Manual*, 286-93; Lane Pederson and Cortney Sidwell Pederson, *The Expanded Dialectical Behavior Therapy Skills Training Manual: DBT for Self-Help, and Individual and Group Treatment Settings*, 2nd ed. (Eau Claire, WI: PESI Publishing & Media, 2017), 33-46; Tali Boritz et al., *Deliberate Practice in Dialectical Behavior Therapy,* 131-39.

Reading Dilemmas while Thinking with Dialectics

1. Personal Dilemma

Re-reading pastors' personal dilemma statements and related experiences of the pastors has led me to make the following Both-And statement: *You want to protect yourself from harm, distress, disturbance, and fatigue (thesis), and you also highly value your pastoral responsibility for the soul who causes these troubles for you (antithesis).* In particular, the following responses taught me how their pastoral identity and related duties help the pastors endure the pain, struggle, and limitations they experienced during their caring interactions:

> **#1: HL**: I don't really know how to deal with them pastorally, but I'm thinking about one thing that I'm trying to apply to my ministry with them… I know that they need to vent [their thoughts and emotions] in that way… If that's the case, shouldn't I [as pastor] be the primary target of that venting?
>
> **#2: JH:** It was extremely painful for me [dealing with the church members with different mental illnesses including schizophrenia] in the first seven or eight years, and I just forced myself to go through and tolerate it. I questioned how I would minister to a church if I couldn't love a single soul.
>
> **#3: Minhwan:** So, you are saying what a pastor or church can do for a person with schizophrenia is just giving love, giving genuine attention to them?
>
> **HC**: Yes. It's like pouring water on a bottomless crock for a very long time.

A core value incorporated into the thesis I identified above is self-preservation. From the Personal Values Card Sort in the appendices, three values aligned with self-preservation stand out: "PROTECT: to protect and keep safe those I love," "SAFETY: to be safe and secure," and "STABILITY: to have a life that stays fairly consistent." These values enable pastors to

replenish themselves from their work-related stress, emotional and relational burdens, and compassion fatigue. However, violating their boundaries and high levels of personal distress from these interactions can impede this important process.

As shown in the excerpts above, the pastors' personal dilemmas are not merely derived from the distress experienced from interacting with an individual experiencing schizophrenia. The dilemmas are also developed when their personal and pastoral identities collide within the context of caring for the individual. The antithesis statement reflects their strong commitment to this pastoral identity. Therefore, the following two values are chosen from the values list: "COMMITMENT: to make enduring, meaningful commitments," "DUTY: to carry out my duties and obligations," and "GOD'S WILL: to seek and obey the will of God." These values commonly represent the pastors' sworn duties to pastor those who come to the church, no matter their conditions or needs. These duties create a sense of unavoidable obligation assigned to them by God when it comes to caring for parishioners. Colliding values and delaying of the practice of pastoral care for individuals in crisis or facing significant challenges, such as schizophrenia, results in regret, shame, and guilt.

Walking a middle path as synthesis attempts to validate the truth in each statement and therefore tries to create a balance between them. My synthetic statement for those struggling with personal dilemmas is: *It is okay to stop or withdraw temporarily when things are too intense and out of control to handle. Asking for help from others does not mean you are giving up your pastoral authority or neglecting pastoral duties (Synthesis).* This middle path's value is "MODERATION: to avoid excesses and find a middle ground." Avoiding forcing pastors to assume more than they can handle while allowing them to remain committed to providing care at moderate levels is the key to the sustainable practice of pastoral care with people with

schizophrenia in the Korean church. This also necessitates changing the care system to solidify the connection between both immediate church and higher-level organizations.

2. Pastoral Dilemma

Using the dialectical thinking approach when analyzing the research participants' difficulties in delivering pastoral care to those living with schizophrenia yields the following thesis and antithesis statements: *You don't want to take on responsibilities beyond your expertise and that you can't keep up with (Thesis). At the same time, as a pastor, you want to continue to be helpful to those who come to the church and are suffering (Antithesis).* As the foundational value of the thesis statement, I chose responsibility, which is related to three values from the Personal Values Card Sort: "GENUINENESS: to act in a manner that is true," "HONESTY: to be honest and truthful," and "RESPONSIBILITY: to make and carry out responsible decisions." While these values are rooted in the pastors' awareness of their limited capabilities in addressing specific care situations arising from their pastoral encounters with individuals living with schizophrenia, their shared nature mandates a humble and prudent acknowledgment of one's constraints and, from this, taking responsibility and appropriate action.

Looking at the antithesis, pastors' wanting to be beneficial and supportive to those suffering from schizophrenia is aligned with three values: "LEADERSHIP to inspire and guide others," "SERVICE: to be helpful and of service to others," and "CARING: to take care of others." These arise during the conflict between being responsibly careful and being urged to provide care immediately. Torn between the urge to withdraw and the urge to intervene, this conflict is evidenced in the following excerpts from three of the pastors:

> **#1: SH:** In my way of looking at things from a theological angle, based on my studies, I think we need to tackle it [schizophrenia] from both angles [medically and spiritually].

There's a part where God can step in for healing, and the church has a role, too. But let's be honest, all I can do is pray for them, and that's about it.

#2: TR: When I talk to the pastors individually, they understand the necessity of welcoming people with schizophrenia in the church and agree with it, but they don't try to introduce it into practice. It's challenging to make it take root in the context of the [Korean] church.

#3: KJ: [During the community meal,] she barely talked. She just ate without talking. She would only answer yes or no when asked, and she didn't even do that at the beginning. But as we got to know each other and became acquainted, she would say, "Yes." As a pastor, I wanted to help her more, but I couldn't do anything except to pray for her, and it kinda felt powerless to me.

What does a synthesis of these two opposing stances look like? I offer this: *Your work is as impactful and meaningful as that of other professionals in providing care to people with schizophrenia, as long as you continue to search for ways to collaborate with the other experts and those with lived experiences (Synthesis).* "COOPERATION: to work collaboratively with others" is the central value in this statement; it underscores the attitude necessary to reclaim relevance in the care of individuals with schizophrenia. This involves assisting them in creating meaning and making decisions in the religious/spiritual dimension—as well as every other dimension—of their life by listening to their lived realities and knowledge of schizophrenia. KJ aptly describes the importance of cooperation in the evaluation of his pastoral journey, emphasizing how it taught him pastoral humility:

KJ: Now that I've been in ministry for about 30 years, I reflect on my early years when I was less experienced. Initially, I believed I could do anything with God's help. However,

although I'm uncertain whether this [the change in his thought] is due to a loss of faith; I still firmly believe in and trust God's power and work even more strongly… [But at the same time,] I think it's crucial to cooperate with professionals, especially in cases like schizophrenia.

3. Relational Dilemma

Pastors are often entwined in complex relationships, so they wrestle with how to position themselves. The dilemmas of this nature convey the conflict between two different desires, encapsulated in the following Both-And statement: *Seeing a conflict, discomfort, or complaint arising in the community under your ministry caused by certain individuals stresses you (Thesis). Simultaneously, you need to take a side with those more vulnerable rather than with your ideals (Antithesis).* Considering the position of the thesis, the ability to avoid breaking group "harmony" is cherished. This orientation can be further explained with the values of "ORDER: to have a life that is well-ordered and organized," and "POPULARITY: to be well-liked by many people." These two values represent the desires of the leaders of any group. About these desires, pastors shared their experiences of being located in relationally sensitive positions with their congregation. I provide two instances of this below:

#1: SH: Pastors have to adapt to the situation of the congregation and the atmosphere of the church. Of course, pastors have a pastoral philosophy, but I think it will be decided by looking at the church's culture or the details of the case that occurs within the church.

#2: KJ: I don't think we can have every individual. We'd love to welcome this lady and our new church family to join, but realistically, not everyone is mature. When you come to the service, but if it's interrupted [by any reason], you get upset and complain. People get frustrated and annoyed when someone sitting next to you is continuously noisy.

Despite experienced or foreseen relational difficulties, the antithesis stance, which was at times unconsciously taken by the pastors, displays the observance of three values: "CHALLENGE: to take on difficult tasks and problems," "COURAGE: to be brave and strong in the face of adversity," and "JUSTICE: to promote fair and equal treatment for all." Even if this choice involves a more precarious path, it appreciates and prioritizes relational justice, which ultimately contributes to the relational well-being of everyone in the community.

Imagining a middle way is aided by drawing on the guiding principle of couple's counseling: Therapists/counselors work for the couple's relationship, not for either individual.[4] Considering the dynamic nature of all relationships, a synthesis statement like the following can be proposed: *As a community of faith, your attention and efforts to address the various relational needs of individuals and the community as a whole are continually shifting, focusing on those whose situations require prioritized care at each moment. This care is practiced through the active participation of everyone in the church at varying degrees.* The request that service to others is the responsibility of all church members, not exclusively pastors, is grounded in the value of "COMPROMISE: to be willing to give and take in reaching agreements." Individuals with schizophrenia are also included in participating in this accountability in ways that are within their capabilities, contributing to the communal goal of serving one another. One of the individuals experiencing schizophrenia in JH's narrative offers insight into how accountability can be practiced in ways that are within the capabilities of the individuals:

> JH: What I was grateful for was that, even though he had a violent tendency, even a person like him, when he came to this spiritual community, this God-seeking community,

[4] Nell J. Lavender, "3 Sins Your Marriage Counselor Should Never Commit," *Psychology Today*, April 7, 2018, https://www.psychologytoday.com/us/blog/the-two-shall-become-one/201804/3-sins-your-marriage-counselor-should-never-commit.

made a hard effort to verbalize that tendency rather than acting on it. Thus, I saw the real person in him rather than having my negative image of them reinforced.

4. Theological Dilemma

In terms of grappling with the uncertain theological realms of understanding schizophrenia as a human experience, the pastors showcased feelings of ambiguity. My critical reading of their struggles results in the following Both-And statement: *It is not pleasant and comfortable for you to deal with uncertainty, paradoxes, and voids in your theology and look as if you are unclear or unauthoritative (Thesis). You are also interested in learning a novel theological idea that benefits you, someone living with schizophrenia, and others in your community with invaluable insight into the meaning of a flourishing faith and life through the lens of someone's lived experience of schizophrenia (Antithesis).* Even when grappling with confusion and vulnerability arising from a theological void concerning the rationale of spiritual care, pastors are undeterred in their commitment to providing care. This drives them to explore alternative theological ideas. Furthermore, their question for the theological exploration is not only situational but also rooted in their belief in the spiritual dimensions of all phenomena:

> HL: I keep encountering these people [with various mental illnesses] in church communities, and it's challenging for me to develop theological ideas about these experiences. I haven't really delved into those; I'm simply trying to interact with them based on the teachings of faith and biblical truth, but I'm unsure if I'm doing it right. Therefore, I believe it would be beneficial if theologians like you conduct research on this and provide [ministers] sound, valid alternatives.
>
> SH: Why did God give that person that disease? When I think about it, it's a mystery. So, I reckon it's just a mystery, and I believe there's God's will in that [for whatever reason].

Given our human nature to resist and defy uncertainty and complexity, the observed values upheld by the pastors are "ACCURACY: to be correct in my opinions and beliefs," "TRADITION: to follow respected patterns of the past," and "AUTHORITY: to be in charge of others." Their rejecting the theological idea of punitive justice for a church member with schizophrenia creates a temporary void, on theological grounds, to see and interpret their vicarious experiences of someone's life with schizophrenia. Some pastors retained a negative connotation of the relationship between mental illness and spiritual conditions, and they continued to preach and practice this belief with theological authority.

Nevertheless, departing from the old-fashioned, detrimental theological stance on individuals experiencing schizophrenia already suggests pastors' willingness to explore new religious/spiritual ideas to comprehend this human experience. While additional exploration in the uncharted areas of theological anthropology is demanded, the pastors' theological epistemic views indicate a willingness to consider new theological interpretations. I identify three values that underlie this stance: "ADVENTURE: to have new and exciting experiences," "COMPLEXITY: to embrace the intricacies of life," "OPENNESS: to be open to new experiences, ideas, and options."

In the light of sanist injustices prevailing in theological dilemmas, the theological exploration of schizophrenia needs a groundbreaking, unprecedented approach taken by a different subject: people with lived experiences of schizophrenia. Out of a plethora of values about this innovative shift, I select "SPIRITUALITY: to grow and mature spiritually," given pastors' profound theological desire to understand and nurture people's relationship with God, and offer the following statement to synthesize two truths inherent in their dilemmas: *Genuinely listening to what others say about their life with schizophrenia and their faith will set you free*

from your fear of not-knowing and pressure to be all-knowing, providing you new knowledge of yourself, others, the world, and what it means to be in relationship with God (Synthesis).

5. Ethical Dilemma

The foundational question of whether to include or exclude a person identified with schizophrenia arises from the basic human instinct to avoid risk. It may be a natural, reasonable response choosing to avoid conflict and other associated risks, given that accepting those whose "different" presence may create confusion and suspicion in the community. Values such as "SAFETY: to be safe and secure," "STABILITY: to have a life that stays fairly consistent," and "COMFORT: to have a pleasant and comfortable life," well depict the portrait of Korean society described above, as well as pastors' choices to avoid conflict and danger. Opposing these values, taking risks can be an adventurous decision: "RISK: to take risks and chances." The juxtaposition of those different values is manifested in the statement, *You prefer to uphold the status quo in the community to keep it stable (Thesis), but at the same time you are willing to take risks if there is a reasonable chance it will benefits you or your community (Antithesis).*

On the pastors' and the churches' end, "COMPASSION: to feel and act on concern for others" can address the issue of inclusion/exclusion, which is deeply related to the existential reality of the group of people with mental disability. Therefore, I acknowledge the observation of compassion is the most value-aligned act of Christian faith. With this confirmation, I urge pastors and the churches they serve to pursue "PRACTICALITY: to focus on what is practical, prudent, and sensible" while also using their imagination to find ways to care for individuals with schizophrenia and get as much as possible.

Your love for the group of people you are in charge of is expressed and experienced through your willingness to keep them safe and protected; those who want to become part

of the community deserve it too. When you reach out to them through your love, they and you are in one community (Synthesis).

Reflecting on his positive takeaway from the experience of ethical dilemma, KJ articulates a shift in his pastoral and ecclesial perspective and approach to welcoming future church goers living with mental disabilities, which is driven by the value of compassion and a focus on practicality:

> KJ: Now, if a lady or a gentleman like her comes to the church, the steering committee wouldn't have to have a long meeting. "We're carrying this gentleman. We go with this lady. What is God asking us to do? Let's discern together." Our response would then align with this type of decision-making process... It would be much easier to just adopt this mindset and not have to think hard about it [whether or not to accept the person].

6. Cultural-Epistemic Dilemma

Stereotypes are designed to help us recognize, communicate, and interact with others by providing a basis to anticipate accurately—in many, but not all cases—what to expect. In their ministry, pastors act upon and treat people identified with schizophrenia according to their stereotyped ideas, whether consciously or not. Given their pastoral duties and burdens, securing certain degrees of control seems to be a reasonable response. And whether they like it or not, they must meet new people inside and outside the church in their identity as pastors. This reality leads me to identify two potential desires regarding their pastoral experiences: *You prefer to be knowledgeable, prepared, and in control when dealing with people and events (Thesis). You are eager to meet new people with diverse experiences you have never experienced before and welcome new knowledge about others' lives (Antithesis).*

Attempts to achieve efficiency in addressing potential threats or harm originated from the urge to keep things under control. These actions result from pursuing "ACCURACY: to be

correct in my opinions and beliefs," "RATIONALITY: to be guided by reason, logic, and evidence," and "POWER: to have control over others" in the practice of ministry and pastoral care, often having justifiable reasons such as protecting the congregation or promoting the church's growth.

Regardless of the ministerial orientation of a church, seeking either a larger or smaller community of faith, communities are visited and joined by new people, and pastors are called upon to meet the needs of these individuals through their pastoral activities. This "newness" can mean meeting new people and encountering and learning unique aspects of current members. Three values embedded facilitate the pastoral encounters to mingle with strangers are: "NOVELTY: to have a life full of change and variety," "NON-CONFORMITY: to question and challenge authority and norms," and "TOLERANCE: to accept and respect those who differ from me." The reason I add in the symbolic meaning of meeting new people is that pastors who previously held negative stereotypes of a person with schizophrenia significantly have changed through contact with a church member with lived expressions of schizophrenia that did not conform to authoritative, psychiatric, or sociocultural explanations. Regarding his experience of maintaining embracing relationships with church members living with schizophrenia, TR presents quite the opposite of the prevailing social images of individuals with schizophrenia in Korea, as his impressions of them. Rather than being perceived as unpredictable, dangerous, violent, unsociable, and unfavorable as neighbors,[5] TR perceives them as individuals capable of fostering meaningful connections and facilitating positive emotional and relational changes within themselves and others:

[5] Sejong Hong, "Hangug reseochi juganripoteu yeoron-sogeui yeoron, Je33ho: Gihoek: Jeongsinjilhwane daehan insig josa" [Korea research weekly report vol. 33: Awareness of mental illness], Korea Research, 2019, https://hrcopinion.co.kr/en/archives/11837.

Minhwan: What positive experiences, if any, have you had as a pastor when meeting with this group?

TR: Well, there are a lot of things that I've gained from it. I realized how challenging it was to understand other human beings. But one thing I can confidently talk about is the joy and gratitude I experienced when I witnessed the understanding, relationships, and recovery that actually occurred [in the meeting].

In developing the following synthesis statement, I chose the value "CURIOSITY: to seek out, experience, and learn new things" as the value that encompasses the two desires in this kind of dilemma, considering the effects of positive reinforcement: *Constantly driven by a curiosity about human beings and new relationships, you move back and forth in that existential learning, sometimes carefully and patiently waiting to verify that what you see is right and safe, and at other times, you daring to move forwards despite your uncertainty to broaden your boundaries and knowledge, not only with people you think you already know well but also with people who come from spaces or backgrounds you are unfamiliar with (Synthesis).*

7. Practical Dilemma

Arising out of realistic, practical concerns regarding the lack of a care system and resources in the Korean church for those living with mental disabilities, the pastors' perceived dilemmatic challenges, including hesitance in further care participation of individuals with schizophrenia, automatically represent two connected values: "REALISM: to see and act realistically and practically" and "PRACTICALITY: to focus on what is practical, prudent, and sensible." While other dilemmas also involve the systemic dimension of difficulties posed to the practice of pastoral care, the dilemmas of this type of nature are more affected by contextual factors rather than individual or communal-level factors. One may question and refute whether a

church is an ideal context for creating a care culture and structure for people with mental illnesses. However, given its faith-oriented, mission-oriented organizational structure, it could still be a better venue than others under specific conditions, as highlighted by JH's recognition of the church's potential:

> JH: I believe that it [establishing a comprehensive care system] would be particularly costly, especially within a capitalist society. However, I also believe it's feasible, particularly if there are church communities genuinely committed to embracing individuals with [Christian] love.

Therefore, based on the pastors' practical dilemmatic narratives, I construct the following statement validating contrary stances regarding the spiritual care of people with schizophrenia:

> *You are realistic enough not to overstretch or overburden yourselves when the organizational, financial, or systemic challenges in providing care to an individual with schizophrenia in the church are obvious (Thesis). Nevertheless, you also believe that the church has the potential for swift reorganizing or resource allocation to be more value-driven, rather than efficiency-driven, and utilized more effectively for arranging care intervention immediately for people with more vulnerabilities if guided by a clear mission, different from bureaucracy (Antithesis).*

I agree with the acknowledgment of the current absence of a relevant care system for people with mental disabilities in individual churches in Korea, which is relatively nonexistent to mediocre compared to the well-organized and funded programs and ministries of Korean mega churches. However, this does not eventually conclude the impossibility of pastoral care in smaller church contexts, which applies to the majority of churches in Korea. Instead of being limited to predetermined conditions of structures or environments, I recognize the three alternative values

that coalesce into the antithesis statement: “CONTRIBUTION: to make a lasting contribution in the world; CREATIVITY: to create new things or ideas; and FLEXIBILITY: to adjust to new circumstances easily.”

If the environment cannot deter the pursuit of pastoral care for the people living with schizophrenia, it really pushes us beyond our limited perspective on how to connect with people through pastoral care; beyond our limited context of spiritual care. Instead, I think these two pillars of values can motivate us to go further: “FRIENDSHIP: to have close, supportive friends” and “HOPE: to maintain a positive and optimistic outlook.”

> *Where there are authentic intentions of friendship and hope, follow the ways to be connected and cared for, in one’s own affordable and accomplishable ways. All gathered share lives and faith under the communion of love and friendship, beyond where they are located, beyond how they currently connect (Synthesis).*

Dialectics of Jesus

In the Gospel of John, Jesus is presented with riddles by his antagonists who seek to accuse, defame, or arrest him based on his response. These conundrums initially appear to demand “the” straightforward, unchallengeable, and irrefutable truth. However, it later becomes evident that there are injustices and malice behind these questions instead of the intention of seeking truth, creating loopholes in the simplified, generalized questions. Perceiving that the nature of these questions necessitate dialectical thinking, Jesus announces answers or solutions to encompass the complex and multifaceted nature of the context and issue.

For instance, in John 8:1-10, when a woman is brought to Jesus by the Pharisees and Scribes, who ask him to judge her, his handling of the case exemplifies how dialectics can be employed in ministry dilemmas. The passage lacks detailed information about the scene, leading

to various interpretations of the anecdote.[6] While the text simply indicates that the woman was caught in adultery through the accusation of the Scribes, scholars raise suspicion about its validity. An alternative interpretive approach suggests that the woman is used as a device by a political group rivaling with Jesus to entrap him.[7] This argument is supported by parallels in the Greek apocryphal texts found in the Hebrew Bible, such as the story of Susanna (Dan 13).[8] The scholars contend that the story of Susanna, falsely accused of engaging in adulterous behavior by the elders who attempted to sexually harass her, and later forced her to trial but was rescued by the wits of Daniel, suggests the possibility that the woman in the Gospel of John is also targeted by her fiancé and the political group conspiring to set Jesus up.[9]

This argument is further supported by the interpretation of Jesus' mysterious behavior of scribbling on the ground. Without sufficient information provided in the text, Jesus' unexpected action draws the attention of biblical scholars. Out of various possible explanations, it is recognized that similar behaviors are found in ancient Middle Eastern accounts, where such actions are considered expressions of repulsive, negative emotions, such as disgust or frustration, towards maleficence and injustice.[10] If this interpretation is valid, Jesus' behaviors can be directed towards the sinfulness of those who not only set the trap for him but also objectify and exploit other human beings for their political gain.

The Scribes demand Jesus' confirmation of the punishment of the woman according to the Mosaic Law. Regardless of their schemes on how to utilize Jesus' words against him, the legal and religious ground to demand the trial for the accused person is premised on the justice of

[6] Raymond E. Brown, *The Gospel According to John (I–XII)*, 1st ed., Anchor Bible 29 (Garden City, NY: Doubleday, 1966), https://doi.org/10.5040/9780300261967.
[7] Brown, *The Gospel According to John*.
[8] Brown, *The Gospel According to John*.
[9] Brown, *The Gospel According to John*.
[10] Brown, *The Gospel According to John*.

God, who does not condone sins.[11] Justice, the rationale behind their request, seems to be a standalone truth that does not allow exceptions. However, in recognizing the insincere and unjust intentions and behaviors of the accusers, Jesus proposes a solution that extends God's mercy to the unfairly accused: Only those who are without sin can stone her (v.7).[12] In the dismissal of those accusing the woman, the story ends with Jesus' declaration of restoring her to community and life: "Neither do I condemn you. Go your way, and from now on do not sin again." (v.12, NRSV). As neither of the values proposed earlier by the Scribes or Jesus—Justice and Mercy—completely resolve the dilemma, Jesus' dialectical approach guides toward accomplishing restorative justice for the woman, irrespective of whether or not she committed the sin.

The story of Jesus being dialectical, and its interpretation presented alongside, provides several implications regarding the application of a dialectical approach to the dilemmas in spiritual care of people with schizophrenia. Firstly, Jesus acknowledges the injustice in the situations that necessitate further exploration of alternative values. Although the initial value, justice, is not what the scribes wanted, it has enough rationale to be upheld and practiced. Jesus acknowledges systemic injustice behind the schemes in the accusation of the woman and objectifying human beings for power and politics. This teaches that spiritual caregivers need to develop to discern and assess injustices embedded in every spiritual care practice.

Secondly, Jesus exemplifies the process of value exploration more holistically, addressing the complicated issues involved in the care of the woman. Presenting mercy as an alternative value, Jesus chooses to protect the woman sinned against by the unjust powerful group. It is also worth noting that Jesus' processing of disgust or frustration over injustices through scribbling behaviors is not led by but consciously respond to emotions.

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[11] Brown, *The Gospel According to John*.
[12] Brown, *The Gospel According to John*.

Lastly, Jesus' handling of the issues aligns with dialectics towards restorative justice as the synthesis. Regardless of whether or not she sins, the declaration and exhortation enable her to reconnect to her regular life, instead of just returning her back to her life without mending her legal/spiritual conditions. Although this will be further discussed in the following final chapter, this restorative approach resembles the recovery approach modified and adopted in the revised intercultural spiritual care of people with schizophrenia proposed soon. That is, the salvation of the woman implies restoration of her life, from being sinned against by social injustices. Likewise, the spiritual care of people with schizophrenia aims to recover in the sense that helps them liberate from unjust sanist oppressions that prevent them from fully restoring their lives.

Conclusion

The last two chapters enable us to critically and creatively understand the caregiving experiences of pastors, especially their dilemmas in interacting with people living with schizophrenia, which are caused by sanist sociocultural ideas and underlying injustices in Korean society and the church. These sanist oppressions hinder both individuals experiencing schizophrenia and pastors and church members, as deeply rooted sanist ideologies and practices interfere with their authentic interactions and connection. In the following final chapter, we will revisit pastoral theologian Carrie Doehring's Intercultural Spiritual Care plan to revise it to accommodate the needs and contexts of spiritual care for people with lived experience of schizophrenia in the church. The chapter will conclude with implications of the research for pastoral and practical theology, and pastoral care, suggesting future research directions indicated by this dissertation.

Chapter 8

Conclusion

This dissertation has examined Korean pastors' spiritual care encounters with individuals living with schizophrenia, during which certain dilemmatic moments arise, negatively influencing the pastoral caregivers' care provision and later their evaluation of the experience with these individuals. Further analysis of their caregiving interactions reveals how certain sanist, life-limiting ideas within Korean society have saturated their perspectives, causing them not to fully participate in the care due to internal and external dilemmas.

By shedding light on the oppressions and injustices (Chapter 6) and the unrealized caregiving values and options (Chapter 7), the critical analysis of the pastors' dilemmas reveals the realities of sanism in Korean society and the church, hindering the connection between individuals with schizophrenia and others, as well as impeding the pastoral care provided by pastors and congregations. This concluding chapter presents how the insights gained from the analysis can be applied to the planning of pastoral care in each congregation, depending on their unique contexts, needs, and resources.

A Revised Intercultural Spiritual Care Model of People with Schizophrenia

While the discussions so far have substantially emphasized the importance of addressing sanist injustices and establishing a culture of care on systemic and organizational levels, pastoral caregivers, particularly the pastor, still require guidelines to lead the process of spiritual care. Doehring draws on the theoretical foundations of works by Judith Herman and Marie Fortune in the final chapter of *The Practice of Pastoral Care* to outline three phases for creating and implementing intercultural spiritual care plans as a co-creative process. She names each phase as

follows: Phase 1 - "Building Trust Through Compassion, Establishing Safety"; Phase 2 - "Mourning Losses, Fostering Accountability"; Phase 3 - "Reconnecting With The Goodness of Life."[1] Each phase integrates her narrative, contextual, and trauma-informed understanding, focusing on compassion and justice in the co-creative, embodied care process based on her rationale for facilitating change in a person in crisis or in need of another's care. I revise Doehring's model with two main focuses: First, I emphasize the goal of spiritual care for people with schizophrenia, prioritizing recovery over cure. Second, I integrate a Mad-affirming, lived-experience-informed approach that refrains from pathologizing people's experiences but instead affirms and validates them.

Applying DBT's dialectical principle, also known as the "middle way," to Doehring's intercultural spiritual care paradigm introduces an intentional initiative to overcome dichotomous and either/or approaches when addressing contrasting choices in the spiritual care of people with schizophrenia. This principle advocates for carefully considering both the overly appreciated and underappreciated values and the shortcomings and potentials of available options. These considerations were previously hastily or indeliberately contemplated. The review and analysis of the interviews evince that the lack of thorough pastoral theological examination results in internal and external conflicts, thus negatively impacting spiritual caregivers, care recipients, their families, bystanders, and the entire community. This finding underscores the imperative to redefine the concept of accountability for all parties involved.

Dialectic creativity is a value that bolsters the dialectical spiritual care process. Pointing out the overlapping process between dialectical thinking and creative thinking, both aiming to present a novel, original idea that replaces the old counterpart in the respective situation,

[1] Doehring, *The Practice of Pastoral Care*, 173-86.

educational psychologist P. K. Arlin asserts that "[the] core of dialectical thinking is fundamentally creative in nature."[2] Creativity can inspire them to overcome their epistemic and logical limits in addressing a variety of dilemmas pastors face in the provision of spiritual care. Considering dialectical thinking as "frame-restructuring," which leads to a "coordination and reconciliation of conflicting descriptions of particular situations,"[3] I recognize creativity as a source of positive reinforcement rather than a dogmatic belief that pressures care practitioners as negative reinforcement.

It is worth highlighting that while the dialectic approach is proposed here based on the anticipated benefits and efficacies in practice, it does not always guarantee the resolution of every dilemma. Resolving dilemmas does not solely depend on caregivers' capacities and knowledge, as caregiving occurs within the intersection of various contexts, diverse issues, individuals, and communities. Also, the availability and limitations of resources vary. Consequently, there may be varying outcomes or results, though the proposed concept is still expected to be practical and valuable.

Likewise, there is a reasonable chance that a spiritual caregiver's role may be significantly limited and remain in Phase 1, depending on the conditions and contexts of care receivers. Scholars and activists have provided insights into this possibility.[4] Despite facing constraints in the caregiving process, I conclude that pastors are still able to undertake transformative, creative spiritual care tasks rather than being entrapped in dilemmas of being relevant or helpful to people who require care. In the interview, SH hypothesizes that even if the

[2] P. K. Arlin, "Dialectical Thinking: Further Implications for Creative Thinking," in *Encyclopedia of Creativity*, 2nd ed., ed. Mark A. Runco and Steven R. Pritzker, (Amsterdam: Elsevier, 2011), 1:385-86.

[3] Arlin, "Dialectical Thinking," 1: 386.

[4] See Rennebohm and Paul, *Mental Health Ministry*; Marion L. S. Carson, "Loving, Discernment, and Distance: Pastoral Care in Schizophrenia," *Journal of Pastoral Care & Counseling* 60, no. 3 (2006): 227-39. PMID: 17059112.

condition of an individual experiencing schizophrenia made communication or interaction extremely difficult, he would still pray for the person from a distance. His comment showcases the potential for ongoing spiritual care if practiced creatively and expanded. For example, pastors or the church can initiate solidarity efforts, collaborating with other individuals experiencing similar mental distress or a larger group/community as an expression of prayer for the person. Even when direct interaction with the specific individual is highly limited, this prayer-like spiritual care aims to transform the sanist cultural landscapes in both society and the church, with the expectation of bringing indirect/collateral benefits to the person eventually as well.

Phase 1: Building Trust through *Anti-sanist, Mad-affirming* Compassion, Establishing Safety *through Collaborative Efforts to Know Person's Lived Experience with Schizophrenia*[5]

In any caregiving relationship, as Doehring specifies, the establishment of trust and safety between caregivers and care receivers is foundational; it is impossible to engage meaningful care interactions between people living with schizophrenia and their spiritual caregivers without trust and safety. Similar to other caregiving or counseling relationships that require psychological and relational work to assist both parties in building a safe and positive space, trust and safety apply to various levels for those directly and indirectly involved in and influenced by the care process. Indeed, given the nature of care receivers' experiences with schizophrenia and the potential crises or adverse impacts these can entail, whether to themselves or others, the work requested in this phase of this specific spiritual caregiving process necessitates additional specific, meticulous, values-driven, and context-informed efforts in securing both trust and safety.

Doehring states that trust is cultivated through caregivers' compassionate acceptance, reflexive listening, and careful work with the stories of care receivers.[6] Compassionate

[5] The italicized phrases in the name of each phase have been added by me.
[6] Doehring, *The Practice of Pastoral Care*, 175.

acceptance in the context of my dissertation may need to be more nuanced than the baseline definition of nonjudgmental compassion given to people from different care contexts because it reflects the necessity for non-pathologizing and mad-affirming perspectives towards the presence and expressions of the lived experience of schizophrenia. These perspectives do not intend to supersede the viewpoint of medicine or psychiatry; instead, their adoption is rooted in the approach of providing care to individuals based on their lived experiences, decisions, and the meaning they draw from these, particularly in the religious/spiritual context, which medical/psychiatric treatment may not fully address.

These perspectives also highlight the issues with pathologizing schizophrenia. Philosopher Robert Chapman offers insight into the difference between "pathologization" and "medicalization" of mental illness.[7] Chapman distinguishes the two related phenomena: the former negatively portrays people's specific behaviors as "abnormal, unhealthy, and requiring special treatment" as pathological, while the latter focuses on the necessity of medical interventions for medical disorders that may be compatible with neurodiversity approaches.[8]

"Mad-affirming," which acknowledges the uniqueness and diversity in the identities and lived experiences of people violently forced into the uniformed psychiatric categories of mental illnesses based on the sanist sociocultural norms of each society, represents a more open and positive approach to the self-explored explanation of people about their life with various expressions of "madness" and their meanings.[9] Adopting non-pathologizing and mad-affirming perspectives, for example, can enable pastors to listen to the stories of people diagnosed with schizophrenia as related to their own unique or religious/spiritual interests without judging

[7] Robert Chapman and Havi Carel, "Neurodiversity, Epistemic Injustice, and the Good Human Life," *Journal of Social Philosophy* 53, no. 4 (December 2022): 624, https://doi.org/10.1111/josp.12456.

[8] Chapman and Carel, "Neurodiversity, Epistemic Injustice, and the Good Human Life," 624.

[9] Menzies, LeFrançois, and Reaume, "Introducing Mad Studies," 10-17.

whether they are hallucination-led, delusional, symptomatic, or entirely irrational or unreal. Instead, they could consider these stories as narratives that contain plots, meanings, symbols, and values, like those of others living without such diagnosis or related experiences, under the guidance of "respect, compassion, and theological reflexivity."[10]

The rationale for incorporating the non-pathologizing and mad-affirming perspectives is also to address the shame imposed on individuals living with mental distress, particularly within the sociocultural and religious/spiritual dimensions of their lives. Doehring's intercultural spiritual care model reveals the intersection of oppressions in the care receivers' contexts by examining how sociocultural systems shape and impact their embedded and espoused theologies.[11] It is crucial for caregivers in spiritual care relationships to grasp and address the relevant prejudices and shame originating from and perpetuated by sanist cultures in society and the church, particularly in the Korean contexts discussed in my dissertation.

I posit that this nuanced, compassionate approach involves lived-experience-informed, justice-aware care that more holistically conveys the inclusion of the people labeled as mentally ill. Non-arguing, non-criticizing, and non-confronting are the strategies for interacting with those with psychosis that are commonly recommended, but these approaches rely on the assumption that individuals with schizophrenia are irrational, non-sensical, and unable to communicate.[12] Moving beyond this sanist assumption, on the other hand, the revised intercultural spiritual carer approach regard their experience as one of many realities.[13] The goal is not to debunk that reality, but to explore and choose what is best for both the caregiver and the care seeker. The

[10] Doehring, *The Practice of Pastoral Care*, 175.
[11] Doehring, *The Practice of Pastoral Care*, 157-64.
[12] For example, Betty Ann Kitchener, A. F. Jorm, and Claire Kelly, *Mental Health First Aid Manual*, 2nd ed. (Parkville, Australia: ORYGEN Youth Health Research Centre, 2010), 60-66.
[13] May, "Relating to Alternative Realities," 142.

revised intercultural spiritual care necessitates care providers to monitor their own emotionally triggered reactions and how these may be associated with their sanist theologies, which assume that the person's non-social conforming expressions or presence. The approach also requires spiritual caregivers to keep watch for signs of shame arising in individuals living with schizophrenia that may stem from their interaction with sanist, life-limiting views or attitudes of the care takers, as described by Doehring.[14]

The concern of whether inclusive, justice-based approaches allow collaboration with medicine/psychiatry can be explored in relation to how to secure safety in the provision of spiritual care to those experiencing schizophrenia. Various pastoral and psychiatric sources recommend referring individuals to medical intervention as soon as they detect expressions deemed as psychosis, including hallucinations or delusions.[15] It is crucial to prioritize safety, but under certain circumstances, I suggest that pastors avoid immediately linking the diagnosis of schizophrenia or displaying non-violent, non-aggressive, non-suicidal, or non-self-harming behaviors with an immediate danger or threat that requires prompt separation or exclusion.

I agree with the notion that pastors should possess basic mental health knowledge. Within the faith community, the ability of pastors or pastoral caregivers to identify any immediate signs of risk or danger entailed in the behaviors of their church members is crucial for keeping themselves, the individual, other pastors, and their community members safe. However, it is also significant to acknowledge the limitations of their screening capacities as non-mental health experts. Indiscreetly and hastily diagnosing or labeling certain behaviors as symptoms of mental illness only leads to increased stigmatization of people with lived experience of madness,

[14] Doehring, *The Practice of Pastoral Care*, 4-6; 173-76.

[15] For example, Kitchener, Jorm, and Kelly, *Mental Health First Aid Manual*, 60-70; American Psychiatric Association, ed., *Mental Health*, 16; Simpson, *Troubled Minds*, 191, Kindle.

exacerbating existing sanist perceptions prevalent within the church. As a result, there should be strategies in place to supplement these limitations, particularly emphasizing collaborative efforts.

Gauging the potential risks arising from the crisis individuals undergo necessitates a review of an individual's history.[16] This information, if available, could be obtained from family, relatives, or friends. However, it should be noted that these tasks may become more challenging, given society's trend toward increased individualization and the deconstruction of the family. This trend has resulted in looser ties than those in traditional family- and community-centered societies. South Korea, in particular, is more impacted by these rapidly burgeoning trends than many other countries but is still in a state of coexistence with influences from both cultures.[17] As a result, there is a growing sentiment in Korea advocating for the shift in responsibility for the care of individuals experiencing severe mental illnesses from their families to the government.[18]

Given this, it is more reasonable and decisive to focus on ensuring collaboration with a diverse group of experts for the task.[19] When it comes to experts, not only should mental health/illness/disability and allied professionals who are qualified by their education and training be included, but also those who are credited and empowered by their experiential knowledge of mental distress, such as peer groups of those living with different lived experiences of mental distress. In my opinion, while appreciating the strengths each group brings, I value highly establishing and consolidating connections with peer groups, especially those who are trained as

[16] David Webb, "Thinking (Differently) About Suicide," in *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies*, ed. Jasna Russo and Angela Sweeney (Ross-on-Wye, Herefordshire: PCCS Books, 2016), 86-96; Peter Bullimore, "The Relationship Between Trauma and Paranoia: Managing Paranoia," in *Psychosis as a Personal Crisis: An Experience-Based Approach*, ed. M. A. J. Romme and Sandra Escher (London: Routledge, 2012), 74-85.

[17] Young-Hee Shim and Sang-Jin Han, "'Family-Oriented Individualization' and Second Modernity: An Analysis of Transnational Marriages in Korea," *Soziale Welt* 61, no. 3/4 (2010): 237–55.

[18] Yun-ju Kim, "Sabeob-Ibwonje, Jeongsinjilhwanjareul 'Swipge Gaduneun' Jedoga Anida" [Court-ordered treatment system is not an "easy measure to lock up" the mentally ill], *Hankyoreh*, accessed January 30, 2024, https://www.hani.co.kr/arti/society/health/1106885.html.

[19] For example, Swinton, *Resurrecting the Person*, 190-91.

peer specialists, as a further initiative of the church's inclusion and solidarity with the community. Furthermore, in an effort to prevent repeating traumatic experiences associated with being admitted and assigned involuntarily to psychiatric treatment, peer support workers and groups, along with their shared identities and experiences, have been shown to have better outcomes for those with intense experiences and who are refusing any formal interventions.[20]

While ensuring safety, it is essential to distinguish between the individual and their experiences of crisis and trauma, which may lead to resorting to violent responses. This distinction does not justify their actions but reflects the intention to trace the roots of their reactions—separating persons from their behaviors—and ponder the most feasible and effective ways to help individuals free themselves from a vicious cycle of violence triggered by trauma. Securing safety involves a meticulous, but not suspicious and judgmental, observation of any signs of immediate risk or danger, reviewing the person's history of violence, and considering other contributing factors that could lead to harming themselves or others. In this, continuing to hold a compassionate view is essential.

Pursuing these two spiritual care goals, building trust and safety, inspired by the metaphor of "walking the middle path," this phase of caring for individuals experiencing schizophrenia is best approached with an orientation centered on the value of connection. Despite its paradoxical nature, it should be understood as a journey of getting to know the person—fostering relationships and integrating the individual into a community that upholds the aligned values of their faith, instead of assessing the individual's fit within the community based on the degrees of risk or deviation in their expressions of schizophrenia. This approach helps us

[20] Shery Mead and Beth Filson, "Becoming Part of Each Other's Narratives: Intentional Peer Support," in *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies*, ed. Jasna Russo and Angela Sweeney (Ross-on-Wye, Herefordshire: PCCS Books, 2016), 109-117.

grapple with the ethical question: Can individuals who are deemed better kept at a distance, considering their conditions or other contextual contributing factors, still be included in diverse and meaningful ways? If the church remains committed to its spiritual care by arranging and advocating for the individual's best interests and wellness, then the answer is yes. This consideration is not limited to this phase but encompasses the entire process of cultivating a spiritual care relationship, which is anchored in learning about an individual on an ongoing basis.

Phase 2: Mourning Losses, *especially those caused by Injustice,* Fostering Accountability *For Recovery*

What does the experience of mental distress cause a person to lose? For individuals, families, and friends, the madness experience diagnosed and/or perceived as psychosis or schizophrenia incurs various levels of loss, either under the direct impacts of the experience or as the result of interaction with sociocultural, relational, or personal factors. Only one-fourth of individuals who experience a first episode of schizophrenia recover to their prior level of functioning.[21] People mourn the loss of cognitive, relational, and affective capacities, as well as related life skills. Additionally, they experience the loss of their status due to the exhibition of their lived experience of mental illness, along with the loss of credibility and reputation related to their professionalism.[22] This loss encompasses interpersonal and relational levels, connecting to both the cause and result of their marginalization in society. Losing control over one's life can be disempowering when relinquishing rights through medical treatments.[23] The experience of getting medicated also, in many cases, makes individuals with these lived experiences question

[21] Torrey, *Surviving Schizophrenia*, 96-100; See also, Martin Harrow et al., "Do Patients with Schizophrenia Ever Show Periods of Recovery? A 15-Year Multi-Follow-up Study," *Schizophrenia Bulletin* 31, no. 3 (January 1, 2005): 723–34, https://doi.org/10.1093/schbul/sbi026.

[22] Poole et al., "Sanism, 'Mental Health', and Social Work/Education;" Kay R. Jamison, *An Unquiet Mind: A Memoir of Moods and Madness* (New York: Vintage Books, 2011),

[23] Burstow, "A Rose by Any Other Name," 79-90.

the meaning of life, given the way many of the drugs used in the treatment of schizophrenia alter subjective experience and the awareness of self, in addition to other adverse side effects.[24] As observed in the interviews, losing the credibility of their religious/spiritual testimony is also a common experience, but one regarded as a relatively smaller loss compared to others under the assumption of its small significance to the condition. Mad Studies Activist and scholar Lauren J. Tenney argues that there are religious/spiritual dimensions and meanings associated with this overall experience of loss.[25] Thus, this unrecognized loss can be critical to those whose religious faith/spirituality undergirds their lives.

Therefore, grief care is an essential spiritual care task for those mourning the losses engendered by their experience of schizophrenia in a sanist society and church. An acute recognition of the systemic oppressions that cause these losses is mandatory for doing this work. Grieving losses caused by social injustices requires unveiling and tackling the presence and impacts of these unjust systems.[26]

At this phase, more actively exploring the religious/spiritual experiences of the care receivers becomes meaningful for the person in continuing with the spiritual care, as Doehring suggests.[27] Doehring's understanding of the religious/spiritual nature of the grieving process can serve as the basis for helping care seekers in their active pursuit of religious/spiritual experiences: "Grieving involves constructing meanings and practices that can deepen a sense of connection with God/the sacred and the web of being that includes self, others, and all of creation."[28] Doehring states this process is impacted and determined by four contributing factors:

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[24] Sandra Steingard, "Clinical Implications of the Drug-Centered Approach," in *Critical Psychiatry: Controversies and Clinical Implications*, ed. Sandra Steingard (New York: Springer, 2018), 119-26.

[25] Tenney, "Spirituality, Psychiatry, and Mad Studies," 293-97.

[26] Diamond, "What Makes Us a Community?," 76.

[27] Doehring, *The Practice of Pastoral Care*, 180.

[28] Doehring, *The Practice of Pastoral Care*, 180.

1) the severity of the loss or violence, 2) the history of unresolved, traumatic losses, 3) psychological vulnerabilities, and 4) family/community support.[29] The varying length of the grief process for each individual should be considered in organizing sustainable care, including considering available resources and energies. Mad Studies provides an alternative perspective to decolonize and decommodify the rationalized, capitalized, and normalized concept of "good grief" that is "gendered, staged, linear, white, and bound by privilege and reason… productive, never interfering with the business, the family, or the community… graceful and always grateful for expert intervention."[30] To "break open the bone" to see what is inside instead of hiding it, Mad Studies teaches to "share one's story, without interruption or overt guidance," which will enable others to tell their story "without shame, without stigma."[31] What pastoral caregivers should look for and foster as they provide companionship in the journey of grief for individuals experiencing schizophrenia is storying. This requires anti-sanist, compassionate interest, and patient listening.

Regarding grief care as spiritual care, communal lamentation through the church can be a great example of grieving together with people experiencing mental distress. Lamentation in Christian scripture is considered a religious/spiritual resource for accompanying those victimized by violence and injustice.[32] Therefore, lamentation, as a collective action of the faith community, possesses a prophetic nature, accusing and unveiling unjust sociocultural structures that perpetuate the oppression of individuals marginalized in society.[33] From liturgies to social justice

[29] Doehring, *The Practice of Pastoral Care*, 180.
[30] Poole and Ward, "Breaking Open the Bone," 95.
[31] Poole and Ward, "Breaking Open the Bone," 100.
[32] Paul Ballard, "The Use of Scripture," in *The Wiley-Blackwell Companion to Practical Theology*, The Wiley Blackwell Companions to Religion, ed. Bonnie J. Miller-McLemore (Chichester, UK: Wiley Blackwell, 2014), 165-66.
[33] "Communal Lament — Center for Action and Contemplation." *Center for Action and Contemplation*, accessed on January 30, 2024, https://cac.org/daily-meditations/the-lands-lament-2023-04-21/.

advocacy, as Doehring lists,[34] participation of the whole congregation in this accusation of sanism embedded in society, as well as in the church, can be practiced through assisting in expressing the diverse emotions of loss such as sorrow, shame, fear, guilt, anger, resistance, despair, and shock. These emotions can appear and disappear throughout the five stages of dying and relatedly grief: “denial”, “anger”, “bargaining”, “depression”, and “acceptance”.[35]

Accountability is a crucial concept that requires redefinition and radical expansion to encompass the diverse responsibilities assigned to and shared by various parties involved in organizing and practicing spiritual care for individuals living with schizophrenia. In this context, the notion of accountability is drawn from Doehring’s model but is interpreted differently to apply to both those with lived experience of schizophrenia and those without such experiences or meaningful contacts that could have provided them with relevant knowledge. In my adaptation, I employ the concept to acknowledge the interconnectedness of individual accountability with that of the entire community to which they belong.

As revealed in the interviews with the pastors, individuals with schizophrenia are typically treated in one of two ways regarding their accountability: Either they are blamed for all of their experiences of schizophrenia and their consequences, or they are exempted from all of their choices and expressions by being considered as will-less patients. The latter stems from a charitable position of protecting those people from legal and moral charges who may lack the interest in making changes initiated by themselves when adequately motivated and assisted in exerting their autonomy. Even if they are in the community, the special status endowed to people diagnosed with schizophrenia renders their presence awkward or invisible (SH, HC).

[34] Doehring, *The Practice of Pastoral Care*, 181.

[35] Patrick Tyrrell et al., “Kubler-Ross Stages of Dying and Subsequent Models of Grief,” in *StatPearls* (Treasure Island, FL: StatPearls Publishing, 2024), http://www.ncbi.nlm.nih.gov/books/NBK507885/.

Here, importing the recovery perspective of mental illness and considering "Capabilities Approaches" to schizophrenia aims to help the individuals set attainable goals for themselves in living in the community with others.[36] This alternative approach involves an in-depth, mutually respectful exploration of how to live together in their faith community by community members, individuals with schizophrenia, and pastoral caregivers functioning as moderators, guided by respect and consideration for the individual's capabilities affected by living with schizophrenia. What if the rules presented by the senior pastor to the group in TR's story as the conditions of their joining were established following an open discussion and consensus among church members, the group, and pastors mediating their concerns and worries? Ensuring everyone's needs and desires are communicated and establishing rules for community life should not serve as grounds for punishment or exclusion. Instead, they are meant to be a shared responsibility for living within the community as legitimate members. Any conditions or experiences of individuals living with others in the faith community can be addressed under the concept of accountability, reflecting their own different needs and capabilities rather than being viewed as unique, exclusive codes of conduct imposed by others.

Accountability is allocated to the community as well. Communal accountability includes community members as active agents in spiritual care for individuals experiencing schizophrenia, thereby expanding the existing care relationship between pastors and individuals to encompass multiple relationships. This task for pastoral caregivers becomes as complicated and challenging as directly providing care to individuals with schizophrenia, given the

[36] The capabilities approach means helping the person explore how to achieve what is socially and personally valued within their own potential activities, rather than focusing solely on current functionings. More about this approach will be explained in the following Phase 3; Jan Wallcraft and Kim Hopper, "The Capabilities Approach and the Social Model of Mental Health," in *Madness, Distress and the Politics of Disablement*, ed. Helen Spandler, Jill Anderson, and Bob Sapey (Bristol: Policy Press, 2015), 83-97.

congregation's lack of interest and motivation. Addressing this challenge necessitates theological works that elucidate the relationship between the suffering of others, particularly their mental distress, and the faith life of each community member. It is crucial to explain that bystanders may lack firsthand experience with schizophrenia, but understanding and living with the lived experiences of others, including their faith lives with schizophrenia, is profoundly relevant and beneficial to their own overall and spiritual wellness. For example, listening to the stories of how the experiences of mental distress have shaped one's identity, life, faith, values, and practices of daily and religious life can broaden people's perspectives on being human, living a life, connecting with others, and having faith as their previous source of religion/spirituality—scriptures, rituals, or practices—has not fully reflected the lived realities of people with lived experience of mental illness in its formation. Currently, Swinton's *Finding Jesus in the Storm: The Spiritual Lives of Christians with Mental Health Challenges* makes the most prominent attempt to present a phenomenological, un-diagnosing theological approach to people's first-person experiences with various expressions of mental distress. The book inspires pastoral caregivers to engage in their theological deliberations and those of the congregation, embracing human experiences previously deemed outside their religious/spiritual interests by genuinely listening to what people with lived experiences of mental distress say about their identities, experiences, and lives in their own languages.

Reclaiming their accountabilities in living in the faith community, along with the practice of spiritual care that explores religion/spirituality for the individuals with schizophrenia and the whole community, requires an ongoing, accompanied personal and communal practice of faith/spirituality to help them to be on track. As recommended by Doehring, the pastoral caregiver has to "help care seekers find keystone habits that become the cornerstone of living out

intentional theologies."[37] This goal also extends to guiding the community, as assuming responsibility for others' souls necessitates ongoing spiritual maintenance. Self-care and spiritual practice, rooted in self-compassion, is essential for caregivers to sustain their unwavering commitment to providing care.[38] Curiosity in otherness as dialectical wisdom can inspire and enlighten this process of knowing others as they are.

Phase 3: Reconnecting with the Goodness of Life, *Connecting to New Opportunities*

Based on the recovery model of mental illness, redirecting one's life toward living a thriving, meaningful, good life, rather than focusing on curing all deficiencies or dysfunctions and returning to a "normal" life, expands ways to reconnect with the goodness of life. The discussion of the spiritual aspects of living a good life includes what it means to be human and live a happy life, which is not premised on the absence of suffering or crisis. Robert Chapman and Havi Carel's discussion of good human life grounded in the neurodiversity paradigm presents what obstructs creating an image of a meaningful, thriving life for autistic people considered neurodivergent that is not constrained by the norms and standards of the neoliberal, sanist, ableist culture we live in.[39] According to Chapman and Carel, epistemic—testimonial and hermeneutical—injustices preclude reflecting the reevaluation of neurodivergent people and their lives beyond the neurotypical perspectives and standards and ultimately from constructing concrete ideas of a good life for them.[40] This argument emphasizes once again the importance of listening to lived Mad-knowledge from legitimate knowers of schizophrenia, extending beyond one specific domain to encompass their religious/spiritual spheres.

Likewise, while spiritual and religious practices can guide the goodness of life even in

[37] Doehring, *The Practice of Pastoral Care*, 183.
[38] Doehring, *The Practice of Pastoral Care*, 183.
[39] Chapman and Carel, "Neurodiversity, Epistemic Injustice, and the Good Human Life."
[40] Chapman and Carel, "Neurodiversity, Epistemic Injustice, and the Good Human Life," 624-26.

the midst of suffering, the concept of spiritual practice and care is frequently confined to cognitive and cognitive-based spiritual domains. For instance, practices such as spiritual dialogue or meditation, which may involve cognitive abilities like introspection or interaction, are commonly regarded as typical spiritual practices. As a result, the practice of religion/spirituality is not recommended, if not forbidden, for people diagnosed with schizophrenia.[41]

With the shifting view indebted to feminist and critical disability perspectives on the epistemology of existing, knowing, and living, I challenge that conventional notion of spirituality regarding the experience of schizophrenia by arguing that a spiritual caregiver can observe, process, and act upon more than what is cognitively-comprehensible and communicable in their caring interaction with those with schizophrenia. Beyond the conventional—normal, able, and sane—ways of communication, spiritual caregivers can be open to the different ways of knowing, experiencing, living, and existing in both spiritual and general life. Spiritual caregivers can read and understand from various channels by direct verbal communication, interactions in person, and embodied, affective ways.[42]

In addition to that, the religious/spiritual expressions on the surface as well as underneath, which become available by knowing about the person's formational histories and the current environments that both significantly affect the person's religious world-making, can help identify what they want to continue to be connected to as the ultimate source of their faith and happiness. To do this, pastoral caregivers collaborate with people with schizophrenia to explicate

[41] For example, Chris Cook and Andrew Powell, eds., *Spirituality and Psychiatry*, 2nd ed. (New York: Cambridge University Press, 2022), 49-70.

[42] For example, spiritual practices presented in the following book include a list of non-cognitive, relational, embodied, mundane art, or existential practices such as "exercise," "mealtime," "everyday relationships," and "gardening."; See Scott W. Alexander, *Everyday Spiritual Practice: Simple Pathways for Enriching Your Life* (Boston: Skinner House Books, 1999).

how the individuals comprehend and deal with the specifically characterized experiences of schizophrenia, such as hallucinations and delusions.

The implication of the expansion of the understanding of spiritual life and practices, predominantly regarded as inaccessible or non-essential, at best, and at worst, as potentially dangerous and harmful for individuals who experience schizophrenia, is that it can offer benefits and advantages in grasping the religious/spiritual meanings of their life and their mental distress experiences, as well as how to endure suffering or struggle with the assistance of faith/spirituality by being continuously mindful and reminded of the fullness of the present life.[43] Some of these approaches involve using creative imagination, embodied approaches, or simply embracing one's existence spiritually.[44] The ways of spiritually reconnecting are unbounded and unlimited as long as they are unharmful and beneficial to those who experience/practice them. Psychologist James Griffith advises, "[adopting] an illness frame for treatment is most important when there are safety concerns, particularly so when there are risks for suicide, violence, or serious self-neglect."[45] The idea proposed here is not to deter or reject the medical care of individuals experiencing schizophrenia but rather to emphasize the importance of incorporating spiritual care alongside medical treatments. The suggestion is to explore more complementary ways of caring for people after they have received medical interventions. The key is not to lean too heavily on one side, and this balance is exemplified in spiritual caregivers' expertise, particularly in language use.

Doehring asserts that pastoral caregivers can fluently employ different levels of

[43] Doehring, *The Practice of Pastoral Care*, 185.

[44] For examples, refer to Part Three of Isla Parker, Joachim Schnackenberg, and Mark Hopfenbeck, eds., *The Practical Handbook of Hearing Voices: Therapeutic and Creative Approaches* (Monmouth: PCCS Books, 2021).

[45] Griffith, *Religion That Heals, Religion That Harms*, 192.

religious/spiritual language—first-order (pre-critical, pre-reflective), second-order (theological reflective), and third-order (interdisciplinary reflective)—to grasp and express the complexities of life and faith.[46] The expression of believing faith by pastoral caregivers, which can contribute to healing schizophrenia, reflects a belief in God's omnipotence that is compatible with an acknowledgment of the necessity of psychopharmacological intervention--second naiveté. It does not have to be an Either-Or approach to choose spiritual or medical care. Such binary thinking prompts a series of questions about how to live, which cannot be answered: What happens after a person is hospitalized, receives psychiatric treatment, and is discharged? What will their life look like while taking medications and living under their effects? What meaningful and fruitful life awaits the person?

In the same vein, reconnecting to what previously constituted their identity and life does not suffice; connecting to new opportunities must ensue. Being deprived of choices and resources in various dimensions of their lives, including personal, vocational, relational, socio-cultural-economic, communal, political, and religious/spiritual, a new lived reality for individuals living with mental disabilities demands a search for new ways to reclaim agency in their lives and status in personal and social venues. Drawing on Amartya Sen's "Capabilities Approach," mental health researcher Jan Wallcraft and medical anthropologist Kim Hopper assert that disability can be regarded as deprivation in facilitating one's functionings ("what a person *actually* achieves") and capabilities ("what he or she could *possibly* achieve"), which is imposed by "the interaction of (a) an individual's personal characteristics (such as age and impairment); (b) the basket of available goods (assets and income); and (c) their environment (social, economic, political, and cultural)."[47] Aligned with the paradigm of recovery, which is

[46] Doehring, *The Practice of Pastoral Care*, 187-88.
[47] Wallcraft and Hopper, "The Capabilities Approach and the Social Model of Mental Health," 87-88.

"not only about overcoming or 'managing' illness, symptoms, or presumed deficiencies… reclaiming the possibility of a real life, the kind of life that people (with choices) want to live,"[48] the approach employed upon the concept of capability is understood as assisting in discovering and implementing the activities that are personally and socioculturally valued, appreciated, and compensated.[49] Wallcraft and Hopper point out that "it is not just about how people actually function, but their having real options, genuine opportunities–the practical *choice*–to function in important ways *if they so wish.*"[50] They provide a list of where to start discerning the possibilities of capabilities for people with schizophrenia, such as "[making] an inventory of what valued 'beings and doings' are currently available to people living with schizophrenia, and documenting the day to day realities of disadvantage, and assessing the capabilities-enhancing potential of existing interventions."[51] While spiritual caregivers may assist this social recovery process of an individual with schizophrenia by cooperating with social workers, peer specialists, or other experts, this suggestion is also utterly applicable to exploring religious/spiritual practices that are realistically available, empowering, and integral to their seeking a journey of holistic recovery.

Choosing the balance in pursuing meaningful lives by reconnecting and connecting to possibilities is undergirded by hope. This hope is not instilled by others but springs from within those with lived experience of schizophrenia emerging through the search for the remaining old goodness and attainable possibilities of new goodness. It involves narrowing the gaps between what is meaningful and achievable for them and the cultural and societal norms that affirm and appreciate those values and goals.

[48] Wallcraft and Hopper, "The Capabilities Approach and the Social Model of Mental Health," 91.
[49] Wallcraft and Hopper, "The Capabilities Approach and the Social Model of Mental Health," 91-92.
[50] Wallcraft and Hopper, "The Capabilities Approach and the Social Model of Mental Health," 92
[51] Wallcraft and Hopper, "The Capabilities Approach and the Social Model of Mental Health," 93.

Implications of Research

Pastoral/Practical Theology

1) Attention to how an individual is led to behave under the interaction of culture and context

My initial research interest originated from an effort to comprehend why pastors and churches frequently exhibit a limited commitment to offering pastoral care for individuals with schizophrenia and, more broadly, mental illnesses. Unlike a mere absence of theological inspiration or motivation leading to action, their sense of incompetence or the perceived irrelevance of their pastoral or ecclesial roles for specific individuals or groups living with schizophrenia arises from challenges and enduring dilemmas posed by the continuous mutual influence between culture and context in shaping and reshaping the landscape of spiritual care. Continuously reflecting on their beliefs, capacities, and perceptions of people with schizophrenia and their lives, shaped by the formative influences of Korean society and culture, pastors encounter relentless challenges of various natures in their pastoral care for individuals identified as experiencing schizophrenia. This occurs as they choose to organize and implement care for receivers while simultaneously overseeing and managing other pastoral tasks, relationships, interactions, theological, ethical, and existential conundrums, demands, constraints, and community dynamics. The dissertation's in-depth analysis of the research participants' dilemmatic experiences illustrates each factor's intertwined influences. It contributes to other research, offering insights into these intricate dynamics within each context and demonstrating how the practical theological chain process of action-reflect-action can be applied to propose more prospective alternatives for addressing the researched issues.[52]

[52] Kathleen A. Cahalan and Gordon S. Mikoski, introduction to *Opening the Field of Practical Theology: An Introduction* (Lanham, MD: Rowman & Littlefield, 2014), 3; Don C. Richter, "Religious Practices in Practical Theology," in Cahalan and Mikoski, *Opening the Field of Practical Theology*, 213.

2) Raising awareness of sanist injustices and oppressions in the church

I anticipate this dissertation will raise awareness of the injustices and oppressions endured by people with psychiatric diagnoses and lived experience of mental distress in the church, which points to the significance of including and affirming these individuals' existence, experiences, and knowledge in the future direction. Reviewing the experiences of Korean pastors providing spiritual care to individuals with schizophrenia and analyzing them, we notice that the religious/spiritual discussion and exploration of severe mental distress, and consequently, pastoral care of people who live with it, do not receive adequate attention, endorsement, and support in the church context. This does not imply a lack of discussion on mental health/illness in theological studies; instead, the relevant discourse has predominantly been led by a myriad of scholars and experts in the field of mental health and illness; however, not enough within the church.

My dissertation concludes that oppressions and injustices committed against people with schizophrenia, and broadly, mental distress, based on sanist ideas and beliefs about their lived experiences in the Korean church, continuously invalidate, devalue, and ostracize their presence, experiences, and contributions to others and the faith community. Therefore, this conclusion calls for more awareness and intervention in the church to address the impacts of sanist theological teachings, practices, and cultures, along with the prejudicial and discriminatory views and treatments of individuals identified with their mental distress experiences prevailing in their respective culture.

Due to the absence of perspectives from individuals directly experiencing schizophrenia, my dissertation cannot present how to embrace and learn from their lived, experiential knowledge pertaining to not only faith life but also life in general. However, the dissertation

attempts to demonstrate how unjust and oppressive ideas towards them hinder people with schizophrenia from their meaningful participation and pursuit of faith in the faith community. By identifying the injustices that render their presence unwelcomed and undervalued, my dissertation lays the foundation for developing a more anti-sanist, holistic inclusion of people with schizophrenia and other mental distress, thus also leading to learn how to value their subjective experiences in the church.

3) Scholarly Attention to Sanism

Lastly, the dissertation raises awareness of sanism as a social ideology receiving little attention in academic work. Compared to its counterparts—racism, ethnocentrism, sexism, heterosexism, ageism, ableism, and classism—sanism, also known as mentalism, a term coined by Judi Chamberlain,[53] has been less discussed and influential in the scholarship of pastoral or practical theology. The more prevalent adoption of the competing term, stigma, has overshadowed sanism in pastoral and practical research. However, stigma sometimes too broadly and generally depicts the struggle of people as discrimination or marginalization, omitting the nuanced understanding of injustice and oppression in people's medical/psychiatric and social treatments related to living with mental distress, being assigned a mental illness diagnosis, and wrestling with related prejudicial stereotypes in a given society and culture.

A deliberate, ongoing focus of pastoral and practical theology on the lived experiences of a group of people facing marginalization is closely linked to pastoral and practical theologians' foundational research interest in the relationship between theory and practice, as well as theory and context.[54] Theologians in those fields adopt a bottom-up approach in constructing theology from people's lived experiences rather than employing a top-down approach that applies

[53] Menzies, LeFrançois, and Reaume, "Introducing Mad Studies," 10-17.
[54] Cahalan and Mikoski, *Opening the Field of Practical Theology*, 2.

universal theories to analyze daily and religious/spiritual practices without sufficient consideration of the uniqueness of the identified groups and their contextual differences. However, failing to capture the subtle, insidious presence of sanist injustice and oppression imposed on people living with mental disabilities, including schizophrenia, poses a significant disadvantage to the fields of pastoral and practical theology regarding this research approach. Sanism can provide a more accurate, justice-sensitive analytic framework for understanding intersectionality among social categorizations, including race/ethnicity, gender/sexual orientation, sociocultural and economic status, and ableism concerning diverse social justice issues. Research on the lived realities of individuals with mental distress and their caregivers in a sanist society can illustrate how other injustices and their associated contextual factors influence and manifest through the oppression of individuals identified with their experience of madness and/or their psychiatric diagnosis.

Furthermore, the analysis of the influences of sanism can deepen the understanding of other social-identity categories by presenting different manifestations in the lived experiences of mental distress among people of color or from other underprivileged, socially marginalized groups. While there has been more research discovering the intersection among different sociocultural factors conducted in the disciplines such as Mad Studies[55] and Critical Mental Health,[56] pastoral and practical theology can contribute to this scholarship by exploring how these phenomena related to people's lived experience of diverse mental distress occur in religious/spiritual dimensions of their life, as well as in different faith/spiritual venues in society. Therefore, the dissertation's presentation of its analysis of sanist societal and cultural ideas in

[55] For example, Diamond, "What Makes Us a Community?," 64-77.

[56] For example, Roy Moodley, Falak Mujtaba and Sela Kleiman, "Critical Race Theory and Mental Health," in *Routledge International Handbook of Critical Mental Health, Routledge International Handbooks*, ed. Bruce M. Z. Cohen (London: Routledge, 2018), 78-88.

Korean society and the church contributes to a heightened interest in the concept and its application to related future research.

Pastoral/Spiritual Care

1) Spiritual Care of People with Severe Mental Distress in the Church

Alongside other research on the genealogy of pastoral care literature on schizophrenia, this dissertation introduces an illustration of spiritual care with people experiencing schizophrenia within the context of Northeast Asian culture. Additionally, while my research focuses explicitly on schizophrenia, its implications can be extended to the pastoral care of people diagnosed with other mental illnesses or mental disabilities for two reasons. First and foremost, my research offers a detailed analysis of pastoral caregivers' dilemmatic moments in caring encounters with individuals with schizophrenia in the Christian church. Examining the diverse nature of these dilemmas and their relationships with underlying sanist sociocultural ideas in Korean society and the church provides researchers and spiritual care practitioners with tools to reflect on their dilemmatic challenges of a similar nature and identify the contributing factors to those challenges. The presentations of the research participants' caregiving experiences and my analysis of their relationship with various contextual factors, including Korean socio-cultural ideas that are prejudicial, discriminatory, and unjust towards those identified with their diagnosis or relevant experience, guide readers to ponder how to theologically address the inherent sanist understandings, practices, and culture in their faith communities.

In acknowledging the dialectical nature of pastoral care with people living with various mental illnesses, this research proposes a context-informed, practical, but also inclusive, lived-experience-affirming, and values-driven approach in planning and implementing care for people experiencing schizophrenia in the church. The application of a dialectics approach to the practice

of spiritual care for this specific population in this dissertation gives insights into pastoral caregiving contexts dealing with similar value-conflicting, paradoxical moments arising from the care of individuals with different mental illness diagnoses or specific troubling expressions of mental distress to themselves or others. Its further implication is that within its constraints and limited resources, a meaningful spiritual care attempt can still be made in ways not previously understood in the church. It goes beyond the responsibility of pastoral care by pastors and congregations that have already organized their system and resources within their community or are running a specialized ministry.

In addition to that, similar to the cases of schizophrenia, an approach that appreciates the lived experience of mental distress and experiential knowledge of the people who experience it has been lacking in research on other mental disabilities. This contrasts with other theological scholarly works, which often focus on physical disabilities.[57] In an effort to balance perspectives predominantly presented by helping professionals, the dissertation encourages more research to discover and present the unheard voices of individuals as epistemic knowers of their diverse experiences of madness unbounded by mental illness diagnoses and psychiatric descriptions.

Lastly, the dissertation proposes a redefinition of the concept of pastoral care accountability, emphasizing that everyone should be actively involved in the care of individuals with schizophrenia. This entails expanding the care relationship beyond the traditional understanding of the relationship between the pastor as the caregiver and the church member with schizophrenia as the care seeker. The responsibility for pastoral care extends to the broader community, with each member of the faith community and the community as a whole, having

[57] For recent examples, Kenny, *My Body Is Not a Prayer Request*; Julia Watts Belser, *Loving Our Own Bones: Disability Wisdom and the Spiritual Subversiveness of Knowing Ourselves Whole* (Boston: Beacon Press, 2023).

obligations to care for both those providing care and those in need of care. This approach ensures that pastoral care, which may require intensive, long-term efforts, is not administered at the expense of someone's sacrifice or exploitation, nor is it abandoned or avoided under the guise of realistic considerations.

2) Church "with": Solidarity with the Group of People Living with Mental Illness

A plethora of scholarly works on schizophrenia and other mental illnesses emphasize the significance of solidarity with people with mental illnesses/disabilities, while generally and vaguely explaining how or with whom to stand in solidarity. When a list of communities/organizations is provided as a resource, usually they are likely government-assisted, non-profit mental health causes, or family organizations.[58] While relationships with them are essential, the suggestion of my dissertation intends to connect with local and "survivor-led" groups of people with lived experience of mental disabilities.

The existence of peer specialists and peer shelters is increasingly appreciated for their vital roles in intervening and bridging individuals in acute crises during their experiences with madness with their own identity and lived experiences.[59] Endorsing their expertise, credited with experiential knowledge and abilities, is one way the church can connect with and broaden relationships beyond specific individuals in crisis triggered during their experiences with schizophrenia. Validating and affirming the values of their work can signal solidarity from the church, providing an opportunity for them to pursue their recovery and build capabilities. (Examples of peer support and specialist groups are listed in Appendix D.)

[58] For examples, the National Alliance on Mental Illness (NAMI), Schizophrenia & Psychosis Action Alliance, Treatment Advocacy Center, etc.

[59] Paek, *Yŏgi uri ka itta*, 215-21.

Moreover, the church's connection with the specific community can support the community's growth led by people with lived experience of mental distress rather than professional experts. Bringing the pastoral care ministry, whether involving a specific individual or a group, into individual churches has proven burdensome and formidable, particularly for small-sized congregations; its scarcity is evident not only in Korean churches but also in North American church contexts. Whether assisting an individual coming to the church or ministering to a group seeking spiritual growth outside the church, the connection established between them can be helpful to and supportive of pastoral caregivers. Because this relationship is built upon collaboration and mutual accountability, treating both parties as equal partners in a solidarity caring relationship rather than under a one-sided relational dynamic.

3) Church "for": Creating Anti-Sanist, Mad-affirming Culture and Society

In the extension of solidarity, transforming culture into a more inclusive, non-discriminatory, and non-stigmatizing one through education and advocacy is emphasized in the literature across various disciplines. My dissertation takes a step further with a more intentional focus: Toward a more anti-sanist, Mad-positive culture. Both goals call for an innovative, justice-value-driven approach to accepting people's subjective experiences without imposing a singular explanation on what they undergo.

At the core of this endeavor is the recognition of the "many realities" experienced by people with schizophrenia within the phenomenon psychiatrically defined as schizophrenia.[60] Their lived experience may hold diverse dimensions with meaning and values for themselves. This implies that these experiences should be treated not merely as symptoms to be removed and cured but as aspects worthy of attention and listening—listening to the phenomenon of hearing

[60] May, "Relating to Alternative Realities," 142.

voices. This necessitates a culture of embracing their experiences without initial judgment and evaluation.

I acknowledge that this approach is not without ethical and pragmatic concerns. I am fully aware that specific experiences and expressions are detrimental and damaging to both the experiencers and those around them, frequently cited in the critiques of this stance.[61] Even suggesting that the risks and harms associated with behaviors and experiences should be assessed within this attempt raises another ethical issue: who should assess and decide?

However, addressing deep-rooted sanist beliefs and practices prevailing in culture and society requires more than a medicalized description of the phenomenon, as prejudices and injustices are not exclusively rooted in the public's misconceptions about its medical causes/aspects.[62] On the other hand, the celebratory, affirming stance of the mad experience is not intended to romanticize or diminish people's pain, suffering, or struggle on various levels. Instead, it is an attempt to create meaning from these experiences and develop unconventional, creative values in the midst of challenges to "build a life worth living."[63] Individuals' religious and spiritual narratives, notably their subjective and direct religious/spiritual experiences, are especially worth affirmatively considering with the Mad-positive theological initiative rather than dismissing them as unreal or irrational if they pose no imminent, dire harm. Therefore, the potential contribution of religion/spirituality has implications for inspiring pastoral care research in other mental distress experiences within and outside Christian and other faith communities.

[61] For example, Torrey, Surviving Schizophrenia.

[62] Hinshaw, *The Mark of Shame*, 155; Diamond, "What Makes Us a Community?," 76; Burstow, "A Rose by Any Other Name," 85-88.

[63] Borrowed from the title of Marsha M. Linehan's autobiography, *Building a Life Worth Living*, her DBT model shares a similar perspective on recovery.

Into the Unknown: Future Research Topics

Reviewing the contributions of this dissertation points to further research interests in the subject. There is a need for a more comprehensive theological focus on personal narratives, encompassing religious and spiritual accounts of individuals living with schizophrenia and other mental disabilities. My dissertation has not covered the voices of people with lived experience of schizophrenia, which I personally feel is a conspicuous limitation and weakness, although my research sheds lights on the sanist injustices with the Korean church of not validating, crediting, and including their experiential knowledge regarding their lives and religiosity/spirituality. A potential theological research project entails the reconstruction of their theology of living with schizophrenia, grounded in their redefinition and revaluation of lived experiences. This involves envisioning a fuller, happier life built and sought under the values constructed by themselves, respected by others, acknowledged, and rightfully compensated by society. This can be followed by a review of religious and spiritual practices that are more relevant and conducive to their spiritual growth and overall wellness. This reconstruction should be approached with careful and deliberate attention to embodied, creative approaches to religiosity and spirituality, given the uniqueness of their subjective experiences. This can pave the way for research directed towards more holistic collaboration among different disciplines and expertise, fostering genuine and equitable care among individuals living with various mental distress, caregivers and all involved.

The findings from this research also inspire a reexamination of the faith lives of those without direct experiences of schizophrenia or other mental distress, encouraging a broader perspective on human diversity. This implication further influences a reconsideration of the meanings of the faith community on both ontological and practical levels. It recognizes that all

relationships within it are interconnected and cannot be disconnected or distant, irrespective of geographic differences.

Conclusion

This exhaustive research does not alter the reality and context for Korean pastors and the church, similar to the challenges faced by churches in North America. The constraints, injustices, and oppression of sanism still loom large. However, within these challenges, a peculiar sense of hope arises as I envision a glimpse of an alternative, middle-path possibility of spiritual care for people living with schizophrenia. This dialectical creative possibility emerges from the narratives of the pastors on the fully swung, dilemmatic pendulum. A closer examination and understanding of the pastoral care narratives of the research participants prompts this shift. It points to the positive prospect that an alternative, anti-sanist, and Mad-affirming spiritual care view can reveal many undiscovered realities and unfulfilled potentials within the lived experiences of individuals labeled as living with madness, specifically schizophrenia.

Appendix A: IRB Research Protocol

1. Date of submission
01/04/2023

2. Project Title
"Critical Pastoral Theology in Caring for People with Schizophrenia and its Caregivers in the Korean Church Context" (tentative title)

3. Name(s) of Researchers

a. Principal Investigator
Minhwan Song

b. Department or Program
Ph.D. in Practical Theology - Spiritual Care and Counseling (Concentration: Spiritually Integrated Psychotherapy)

c. Advisor (with email address)
Dr. K. Samuel Lee, slee@cst.edu

4. Project Period (beginning and ending)
The project will begin in January 2023 and end in December 2023.

5. Proposed funding sources, if applicable. Identify any potential conflicts of interest.
This project is not sponsored or funded and does not contain any possibility for conflicts of interest.

6. Summary of the research objective(s) (Explain what you hope to learn, demonstrate or achieve in 1 paragraph)
In this project, the researcher intends to learn how pastoral caregivers' theological understanding of schizophrenia impacts their caregiving experiences for people with schizophrenia. The research is designed to explore the narratives of caregivers in ministerial settings. The researcher will observe how people's theological assumptions on schizophrenia are linked with their positive and negative caregiving experiences and how those play a role in meaning creating. The research will seek for an alternative approach to a premodern, spiritual or medical model of working with severe mental illness; it will also seek for critical pastoral theology which is life-giving for all persons involved in caregiving of the schizophrenia patients. The critical pastoral theology will contribute to empowering patients and their caregivers.

7. Brief summary of the procedures, tests, or activities to be utilized during the course of the research in order to collect data.

The research employs a one-to-one interview method for eight research participants: six-seven parish pastors who have experiences of caring for a church member living with schizophrenia. Each interview will take up to 90 minutes, during which participants will share their caregiving experiences and theological views on mental illness as an experience of suffering. The interview will be conducted through Zoom video chatting and the entire session will be video recorded with each participant's consent. Depending on the interviewee's preference, the interview process will be conducted either in the Korean or English language. All interviews will be transcribed. The recorded videos and the transcriptions will be kept on my computer, which will be password-protected and encrypted.

8. Describe the population(s) from which participants will be recruited, plans for the recruitment, and the consent procedures to be followed.

Participants must be at least 18 years old. Participants must identify themselves as Korean or Korean American. Participants must have experience of providing care for a person diagnosed with schizophrenia in the church as pastor. Participants will be recruited from Protestant Christian churches. Announcements about recruitment of participants will be sent through e-mail to the pastors affiliated with the Annual Conference of the Korean Methodist Church in the United States of America and South Korea, with the assistance of the conference staff.

9. Summary of any risks of the topic, method, or to the population involved in the research plan.

The project contains a few minimal risks to the research participants. In sharing their life events with a family member or experiences of witnessing a parishioner with schizophrenia, participants may experience emotional distress such as sadness, shame, anxiety, or fear; of course, it is possible that research participants may experience catharsis or understanding about their past experience through the interview. Participants are given the right to withdraw from the research at any point of the research without any penalty, and all data gathered from them will be discarded immediately.

10. Describe how participants' privacy and dignity will be protected.

a. Describe the procedures to assure confidentiality in the use, storage, and disposal of primary data.

Research data gathered through video recording and its transcript will be accessed, handled, and kept by the primary researcher on his computer which will be password protected and encrypted; any personally identifiable information about the research participants will be disguised. Only pseudonyms will be used. Their church membership will not be disclosed.

b. Indicate how long data will be maintained, where it will be kept, how it will be protected, and how it will be destroyed.

Recorded interviews and transcripts will be kept until May 31, 2026, after which time all the data will be permanently erased.

11. Include a copy of Informed Consent Form to be used.
Please see the attached.

12. Include the faculty advisor's endorsement of the research design.
Please see the attached.

Appendix B: Informed Consent to Participate in Research

Identification of Investigator and Purpose of Study
You are invited to participate in a research study, entitled "Critical pastoral theology in Caring for schizophrenia and its Caregivers in the Korean Church Context" (tentative title) The study is being conducted by Minhwan Song under the supervision of Dr. K. Samuel Lee of Claremont School of Theology, 1325 N. College Ave; Claremont, CA 91711, slee@cst.edu, 909-447-6331.

The purpose of this research is to examine the theological dimensions of the pastor's caregiving experiences of people with schizophrenia. Your participation in the study will contribute to a better understanding of how the pastoral caregivers' theology of mental illness impacts their caregiving experience and its implication for constructing an alternative theology and caregiving practice that empowers and benefits those involved in caregiving. You are free to contact the investigator using the information below to discuss the study.

minhwan.song@cst.edu
1325 N. College Ave., W-261
Claremont, CA 91711
(740) 833-5415

To be eligible to participate in the research study:
- You must be at least 18 years old to participate.
- You must be Korean or Korean American.
- You must be a Protestant Christian pastor/minister having pastoral experience with a parishioner with schizophrenia.

If you agree to participate:
- The individual will participate in a 90-minute, one-to-one interview. There may be a briefer follow-up interview after the first interview.
- The interview will be conducted through Zoom (video conferencing). The whole interview session will be video recorded for research purpose only. The video recording will be kept confidential and will not be shared with anyone else, other than the faculty advisor.
- The interview will be conducted either in Korean or English, depending on individual's preference.
- Your participation will contribute to studying the relationship between theological beliefs about mental illness and caregiving experiences.
- The purpose of this study is to gain insight into practical theology, pastoral care and/or spiritual care. Participation in this study should not be regarded as—or substituted for—therapy by a licensed professional.

Risks and Confidentiality of Data
There are a few minimal risks to the human participants. In sharing their experiences of witnessing/interacting with a parishioner with schizophrenia, participants may experience

emotional distress such as sadness, shame, anxiety, or fear; of course, it is possible that research participants may experience catharsis or understanding about their past experience through the interview.

Your personal information, including name and contact information, will be treated as confidential and will not be publicly released. Research data gathered through video recording and its transcript will be accessed, handled, and kept by the primary researcher on his computer which will be password protected and encrypted. Any personally identifiable information about the research participants will be disguised and only pseudonyms will be used. Your church membership will not be disclosed.

When the results of the research are published or discussed in conferences, no information will be included that would reveal your identity or personal information. Your information including recorded interviews and transcripts will be kept until May 31, 2026, after which time all the data will be permanently erased.

Participation or Withdrawal
Your participation in this study is voluntary. Participants are given the right to withdraw from the research at any point of the research without any penalty, and all data gathered from them will be discarded immediately. If you do not want to participate, you may simply stop participating by notifying the researcher of your decision.

Contacts
If you have any questions about the study or need to update your email address, please contact the primary investigator Minhwan Song at (740) 833-5415 or send an email to minhwan.song@cst.edu**,** or contact the advisor Dr. K. Samuel Lee at 909-447-6331 or send an email to slee@cst.edu. This study has been reviewed by Claremont School of Theology Institutional Review Board and the study number is [-------].

Questions about your rights as a research participant.
If you have questions about your rights or are dissatisfied at any time with any part of this study, you can contact, anonymously if you wish, the chair of the Institutional Review Board by email at irb@cst.edu.

Thank you.

SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided above. I have been given an opportunity to ask questions and all of my questions have been answered to my satisfaction. I have been given a copy of this form.

_____

Name of Participant

_____ _____

Signature of Participant *Date*

_____

Address

_____ _____

Phone *Email*

SIGNATURE OF INVESTIGATOR

_____ _____

Signature of Investigator and Date (same as participant's)

Appendix C: Personal Values Card Sort

Personal Values Card Sort

Authors: William R. Miller, PhD, Janet C'de Baca, PhD, Daniel B. Matthews, PhD, & Paula L. Wilbourne, PhD
from the University of New Mexico Department of Psychology

Update: 2011

User Information

The Personal Values Card Sort is intended to help people clarify their own central values and consider how they might reflect those values in their daily lives. The usual procedure is to have the person sort the cards into 3-5 piles based on how important each value is. This set provides five cards to designate piles:

Not important to me
Somewhat important to me
Important to me
Very important to me
Most important to me

Next, have the person identify the 5-10 values that are most important to him or her. This might simply be the "most important" pile unless it contains more than 10 or fewer than 5 cards. Then have the person rank order these top values, with 1 being the most important or central to the person, 2 for the next most important and so on. There is a serial number on each card to facilitate recording and retaining a person's rated priorities.

The value of this process is often in the interview that follows, although the card sorting process can be useful in itself. You can find out more about the person's core values by asking open questions and following with reflective listening. Some examples of evocative questions you might ask include:

What does [value] mean to you?
Why did you choose this as an important value for you? In what ways is this important to you?
How have you shown this core value in your daily life?
In what ways could you be even more true to this value?

This process can strengthen your understanding of the person and teach you much about the person's guiding principles for living.

Designed for Avery 5371 Business Card Template

The Personal Values Card Sort is in the public domain and may be copied or adapted without further permission.

Personal Values Card Sort

William R. Miller
B. Matthews

Janet C'de Baca Daniel
& Paula Wilbourne

University of New Mexico, 2011

Designed for Avery 5371
Business Card Template

The Personal Values Card Sort is in the public domain and may be copied or adapted without further permission.

Not Important to Me

Somewhat Important to Me

Important to Me

Very Important to Me

Most Important to Me

Other value:

Other value:

Other value:

ACCEPTANCE

to be accepted as I am

1

ACCURACY

to be correct in my opinions and beliefs

2

ACHIEVEMENT

to have important accomplishments

3

ADVENTURE

to have new and exciting experiences

4

ART

to appreciate or express myself in art

5

ATTRACTIVENESS

to be physically attractive

6

AUTHORITY

to be in charge of others

7

AUTONOMY

to be self-determined and independent

8

BEAUTY

to appreciate beauty around me

9

BELONGING

to have a sense of belonging, being part of

10

CARING

to take care of others

11

CHALLENGE

to take on difficult tasks and problems

12

COMFORT

to have a pleasant and comfortable life

13

COMMITMENT

to make enduring, meaningful commitments

14

COMPASSION

to feel and act on concern for others

15

COMPLEXITY

to embrace the intricacies of life

16

COMPROMISE

to be willing to give and take in reaching agreements

17

CONTRIBUTION

to make a lasting contribution in the world

18

COOPERATION

to work collaboratively with others

19

COURAGE

to be brave and strong in the face of adversity

20

COURTESY

to be considerate and polite toward others

21

CREATIVITY

to create new things or ideas

22

CURIOSITY

to seek out, experience, and learn new things

23

DEPENDABILITY

to be reliable and trustworthy

24

DILIGENCE

to be thorough and conscientious in whatever I do

25

DUTY

to carry out my duties and obligations

26

ECOLOGY

to live in harmony with the environment

27

EXCITEMENT

to have a life full of thrills and stimulation

28

FAITHFULNESS

to be loyal and true in relationships

29

FAME

to be known and recognized

30

FAMILY

to have a happy, loving family

31

FITNESS

to be physically fit and strong

32

FLEXIBILITY

to adjust to new circumstances easily

33

FORGIVENESS

to be forgiving of others

34

FREEDOM

to be free from undue restrictions and limitations

35

FRIENDSHIP

to have close, supportive friends

36

FUN

to play and have fun

37

GENEROSITY

to give what I have to others

38

GENUINENESS

to act in a manner that is true to who I am

39

GOD'S WILL

to seek and obey the will of God

40

GRATITUDE

to be thankful and appreciative

41

GROWTH

to keep changing and growing

42

HEALTH

to be physically well and healthy

43

HONESTY

to be honest and truthful

44

HOPE

to maintain a positive and optimistic outlook

45

HUMILITY

to be modest and unassuming

46

HUMOR

to see the humorous side of myself and the world

47

IMAGINATION

to have dreams and see possibilities

48

INDEPENDENCE

to be free from depending on others

49

INDUSTRY

to work hard and well at my life tasks

50

INNER PEACE

to experience personal peace

51

INTEGRITY

to live my daily life in a way that is consistent with my values

52

INTELLIGENCE

to keep my mind sharp and active

53

INTIMACY

to share my innermost experiences with others

54

JUSTICE

to promote fair and equal treatment for all

55

KNOWLEDGE

to learn and contribute valuable knowledge

56

LEADERSHIP

to inspire and guide others

57

LEISURE

to take time to relax and enjoy

58

LOVED

to be loved by those close to me

59

LOVING

to give love to others

60

MASTERY

to be competent in my everyday activities

61

MINDFULNESS

to live conscious and mindful of the present moment

62

MODERATION

to avoid excesses and find a middle ground

63

MONOGAMY

to have one close, loving relationship

64

MUSIC

to enjoy or express myself in music

65

NON-CONFORMITY

to question and challenge authority and norms

66

NOVELTY

to have a life full of change and variety

67

NURTURANCE

to encourage and support others

68

OPENNESS

to be open to new experiences, ideas, and options

69

ORDER

to have a life that is well-ordered and organized

70

PASSION

to have deep feelings about ideas, activities, or people

71

PATRIOTISM

to love, serve, and protect my country

72

PLEASURE

to feel good

73

POPULARITY

to be well-liked by many people

74

POWER

to have control over others

75

PRACTICALITY

to focus on what is practical, prudent, and sensible

76

PROTECT

to protect and keep safe those I love

77

PROVIDE

to provide for and take care of my family

78

PURPOSE

to have meaning and direction in my life

79

RATIONALITY

to be guided by reason, logic, and evidence

80

REALISM

to see and act realistically and practically

RESPONSIBILITY

to make and carry out responsible decisions

81

RISK

to take risks and chances

82

ROMANCE

to have intense, exciting love in my life

83

SAFETY

to be safe and secure

84

SELF-ACCEPTANCE

to accept myself as I am

85

SELF-CONTROL

to be disciplined in my own actions

86

SELF-ESTEEM

to feel good about myself

87

SELF-KNOWLEDGE

to have a deep and honest understanding of myself

88

SERVICE

to be helpful and of service to others

89

90

SEXUALITY

to have an active and satisfying sex life

91

SIMPLICITY

to live life simply, with minimal needs

92

SOLITUDE

to have time and space where I can be apart from others

93

SPIRITUALITY

to grow and mature spiritually

94

STABILITY

to have a life that stays fairly consistent

95

TOLERANCE

to accept and respect those who differ from me

96

TRADITION

to follow respected patterns of the past

97

VIRTUE

to live a morally pure and excellent life

98

WEALTH

to have plenty of money

99

WORLD PEACE

to work to promote peace in the world

100

Appendix D: Peer-Led or Lived Experience-Friendly Organizations in South Korea

1) 사단법인 정신장애와 인권 '파도손'

Location: Seoul, South Korea
Email: padoson119@hanmail.net
Website: https://padoson.org

2) 세바다: 신경다양성 지지모임

Location: Online
Email: sebadaoceans@gmail.com
Website: https://blog.sebada.kr

3) 한국정신장애인자립생활센터

Location: Seoul, South Korea
Email: kmdpcil@daum.net
Website: http://www.kmdpcil.com

4) 마포정신장애인자립생활센터

Location: Seoul, South Korea
Email: Mail.mpcil0723@daum.net
Website: http://www.mmdcil.or.kr

5) 송파정신장애동료지원센터

Location: Seoul, South Korea
Email: peer_supported@naver.com
Website: http://www.peersupported.or.kr

6) 설악어우러기 (조현병및 정신질환자의 재활을 위한 모임)

Location: Sokcho-si, Gangwon Province, South Korea
Website: https://www.facebook.com/groups/829454347791577/

7) 경기동료지원센터 (경기우리도)

Location: Gyeonggi-do, South Korea
Website: https://www.youtube.com/@gg_center

8) 부산정신장애인자립생활센터 (희망바라기)

Location: Busan, South Korea
Email: huimang2015@naver.com
Website: cafe.naver.com/busanmania

9) 광주정신장애인자립생활센터

Location: Gwangju, South Korea
Website: https://blog.naver.com/jish2946

10) 경남정신장애인자립생활센터

Location: Changwon-si, South Gyeongsang Province, South Korea
Email: gpcil420@daum.net
Website: http://www.gpcil.co.kr/

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